San Francisco
Medical Center
LIBRARY
UNIVERSITY OF CALIFORNIA

University of California · San Francisco Medical Center LIBRARY

Digitized by the Internet Archive
in 2016 with funding from
The National Endowment for the Humanities and the Arcadia Fund

https://archive.org/details/michiganmedicine692unse

michigan medicine

U. C. SAN FRANCISCO
MEDICAL CENTER LIBRARY
JUL 28 1970

**The 1970
MSMS Annual
Session Opens
With the Convening
Of the House of Delegates
Sept. 20-22**

FEATURES IN THIS ISSUE

- *Anemia in Head Start Children*
- *Making Medical Education More Relevant*
- *Proposed MSMS Constitution Changes*

**Michigan State Medical Society
July 1970, Volume 69, Number 13**

Block off Your Calendar for MSMS Scientific Sessions Sept. 23-24

261224

NOW... a new sponsored insurance plan

THE ULTIMATE IN INSURANCE PROTECTION

MSMS PERSONAL PRESTIGE POLICY

**DESIGNED FOR AND SPONSORED BY THE
MICHIGAN STATE MEDICAL SOCIETY**

Remember *Yesterday's* Liability Limits Invite Financial Disaster *Today.* The Answer to this Dilemma is Provided in This Comprehensive Policy.

Here are some of the things it does:

- ★ **PROVIDES LIABILITY COVERAGE ABOVE BASIC INSURANCE IN AMOUNTS OF $1,000,000 TO $5,000,000**
- ★ **APPLIES TO ALL EXPOSURES SUCH AS PROFESSIONAL LIABILITY, AUTOMOBILE, OFFICE PREMISES, RESIDENCE, BOATS AND AIRCRAFT**

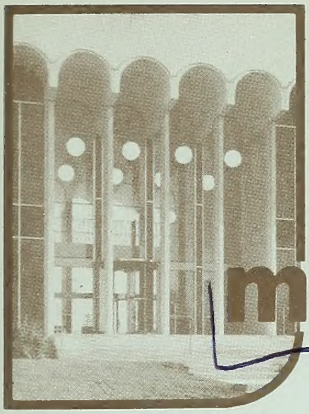
AND ALSO PROVIDES A MAJOR MEDICAL SECTION UP TO $25,000 TO SUPPLEMENT YOUR BASIC HEALTH PLAN

CALL US COLLECT: 517 484-2578 TO LEARN FIRST HAND HOW WE CAN PROVIDE YOU WITH THIS NEEDED COVERAGE AT A REASONABLE COST.

bps **BEN P. STRATTON AGENCY, INC.**
ESTABLISHED IN 1937

**19400 WEST TEN MILE ROAD
SOUTHFIELD, MICHIGAN 48075
357-5083**

**107 N. BUTLER BLVD.
LANSING, MICHIGAN 48903
(517) 484-2578**



Breaking News
June 1970, Volume 69, Number 12
Michigan State Medical Society

U. C. SAN FRANCISCO
MEDICAL CENTER LIBRARY
JUL 21 1970

michigan medicine

Stimulating 1970 MSMS Annual Session Developing for Sept. 20-24 in Detroit

A chance to debate top medical issues . . . to learn the latest medical developments . . . to hear experts in many medical fields . . . awaits the Michigan physician planning to attend the 1970 Annual Session of the Michigan State Medical Society. The dates are Sept. 20-24 at the Sheraton-Cadillac Hotel, Detroit.

The first three days of the Annual Session will be devoted to the annual meeting of the MSMS House of Delegates, which regularly commences at 8 p.m. Sunday and concludes Tuesday evening.

The "Current Controversies In . . ." meetings inaugurated in 1969 will be continued in 1970, with the topics, scheduled from 8:30 to 11 a.m. Wednesday, to be "Recertification and Relicensure of Physicians," and "Does the Annual Physical Serve a Useful Purpose?"

Other meetings of general interest will include "The Clinical Aspects of Pollution," from 8:30 to 11 a.m. Wednesday, and a special program from 2 to 5 p.m. Wednesday on exercise and the heart, arranged by the AMA, MSMS, the Michigan Heart Association and the President's Council on Physical Fitness.

Specialty groups and Sections meeting on Wednesday will include internal medicine and the Michigan Diabetes Association, allergy and applied immunology, urology, pediatrics and the Michigan Branch, American Academy of Pediatrics, plastic surgery, physical medicine, gastroenterology, radiology and the Michigan Radiological Society, otolaryngology, ophthalmology, dermatology, public health and preventive medicine, the Michigan Heart Association and the American College of Chest Physicians, Michigan Branch.

On Thursday the following Sections and specialty groups will meet: obstetrics and gynecology, pathology and the Michigan Society of Pathologists, surgery, thoracic surgery and the Michigan Society of Thoracic Surgeons, general practice, neurology, proctology, anesthesiology and the Michigan Society of Anesthesiologists, the Michigan State Chapter of the American College of Emergency Physicians, psychiatry and the Michigan Society of Psychiatry and Neurology, occupational medicine and the Michigan Society of Occupational Physicians, orthopedic surgery and the Michigan Society of Orthopedic Surgeons, neurological surgery, and the Michigan Committee on Trauma of the American College of Surgeons.

Running simultaneously with the Scientific Sessions will be four all-day postgraduate courses limited in attendance and open only by separate registration. They will be held at the nearby Howard Johnson Motor Hotel.

Mr. Brenneman Resigns To Enter Senate Primary; Mr. Tryloff New Director

Hugh W. Brenneman, executive director of MSMS for six years, is now campaigning for the Michigan Senate after resigning his post with MSMS. Warren F. Tryloff is new MSMS executive director, appointed by The MSMS Council.

Mr. Brenneman, who has served MSMS for 24 years, will seek the Republican nomination August 4 for the Michigan Senate from the 24th District. There are six candidates in the primary for the Republican nomination to succeed Harold Hungerford (R) who is not a candidate.

Mr. Tryloff has been with MSMS since 1954 and has served as its associate executive director for six years.

The news about Mr. Brenneman and Mr. Tryloff broke as this issue was at the printers. Further details will be forthcoming.

Frederick Weissman, M.D., Southfield, right, was the first member of MSMS to enroll for the new sponsored Personal Prestige Policy. He and Ben P. Stratton, MSMS Insurance Administrator, right, discussed details of the new plan. Doctor Weissman was Chairman of the MSMS Committee on Professional Insurance Plans when the Committee began a comprehensive study of excess liability insurance plans at the request of The Council. He is now Advisor to the Committee.

Some Medical Bills Move Through State, National Legislative Action

Legislative action has been made on some medical proposals of interest to members of MSMS, as of this report, prepared June 10.

However, the Michigan Legislature is currently concentrating on appropriations bills which must be passed by July 1 to be included in the fiscal year, and medical bills are not currently of top priority. The Legislature is expected to adjourn by June 26, though a definite adjournment date has not been established.

The MSMS-sponsored HB 4198, to extend the immunity of the "Good Samaritan" law to ambulance personnel acting on instructions from a physician or a nurse while transporting a patient to a medical care facility, has been advanced to its "third reading" on the floor of the House, the last step before passage.

HB 4125, 4128 and 4239, all reclassifying marijuana as a "dangerous drug," and removing it from the narcotics drug list, have been reported from the Public Health Committee and are on "general orders" in the House, at the point of general debate. All three are supported by MSMS.

Two bills, HB 4627 and HB 4628, to allow the governor to appoint the 25-member boards of Blue Cross and Blue Shield including only three M.D.s each, have been reported out of committee and are on the House floor for debate.

Meanwhile, the important Social Security Amendments of 1970, HR 17550, have been passed by the U.S. House of Representatives, as expected. The Senate Finance Committee is now holding hearings on the amendments. The administration was to testify June 17.

The Social Security amendments, among other changes, would give persons eligible for both Part A and Part B benefits the option to have their health care provided by a Health Maintenance Organization (a prepaid group or other capitation plan) with the government reimbursing the HMO on a capitation basis not to exceed 95% of the cost of Medicare benefits.

Doctor Smathers New WCMS President-Elect; Doctor Whiteley Succeeds Doctor Fryfogle

Robert K. Whiteley, M.D., Detroit, was installed June 1 as new president of the Wayne County Medical Society, succeeding James J. Fryfogle, M.D., who served as 1969-70 president.

At the same meeting, Homer M. Smathers, M.D., Detroit, was introduced as president-elect, and Ned I. Chalat, M.D., was elected secretary. James C. Danforth, Jr., M.D., 1968-69 president, is new WCMS trustee.

Doctor Whiteley, who was WCMS president-elect during 1969-70, has been a member of the MSMS Council since 1963 and was chairman of the MSMS Finance Committee. He has also served his community as president of the local school board.

Health Council's Summer Careers Program Expanded to 80 Detroit Youth

Approximately 80 students at Detroit's Northwestern and Martin Luther King High Schools will take part this summer in the second six-week Summer Exploratory Experience Program in Health Professions.

The program was initiated with 40 students at Northwestern High in the summer of 1969, offering racial minority students the opportunity to learn about and participate in health careers.

This year's programs will be similar to last summer's, the first of its kind in the nation. The 80 students, recommended by science teachers and guidance counselors, will spend three hours daily in class at their high schools and an additional three hours daily assisting the professionals at work in eight different hospital departments.

Doctor Evans Named Acting WSU Medical School Dean

A three-man administrative committee, appointed by Wayne State University President William R. Keast, will provide interim leadership of the university's School of Medicine starting July 1 until a new dean can be named.

Chairman and acting dean after July 1 is Tommy N. Evans, M.D., professor and chairman of the Department of Gynecology and Obstetrics. Others on the committee are Jacob L. Chason, M.D., professor and chairman of the Department of Pathology, and Lawrence W. Weiner, M.D., professor of microbiology and director of Conjoint Teaching Services.

Michigan Delegates Have Important Part In AMA Convention June 21-25

Michigan delegates will check in June 20, at the Palmer House in Chicago to begin their contacts to support two Michigan candidates for AMA offices. The elections will be held June 24 during the AMA Convention.

Otto K. Engelke, M.D., Ann Arbor, is running for the national office of vice president of the American Medical Association, while John W. Moses, M.D., Detroit, is seeking a seat on the AMA Council of Medical Education.

Several hundred Michigan physicians will be attending the annual convention and a number of them will be presenting papers. Donald N. Sweeny, Jr., M.D., Detroit, is chairman of the Michigan Delegation to the AMA.

The Michigan physician has many aids available in the form of printed publications. Check any item(s) desired from the list below and mail to MSMS, 120 W. Saginaw St., East Lansing 48823. (Your address is already on the back.)

__________AMA folder listing publications available for parents and children about drugs, alcoholism, smoking, VD, sex education

__________AMA booklet, "Your Friend the Doctor," written to help small children be more at ease when they visit a physician

__________Michigan Health Council catalog listing available drug information materials.

July 1 Deadline for Nominations For Certificates of Commendation

County medical societies may continue to make nominations until July 1 for recipients of MSMS Certificates of Commendation to be presented at the 1970 Annual Session in Detroit in September. One or more nominations may be made by each county society.

The awards may be made for both scientific and/or public service to one or more physicians annually who distinguish themselves in the medical professions.

The biographic forms sent in an early mailing to the county medical societies are to be filled in and sent to The Committee on Certificates of Commendation, MSMS, Box 950, East Lansing 48823.

Last year's recipients of the Certificates of Commendation were Harold A. Furlong, M.D., Pontiac; W. W. Jack, M.D., Grand Rapids; Albert C. Kerlikowske, M.D., Ann Arbor; Robert C. Prophater, MD., Bay City; Arthur L. Tuuri, M.D., Flint, and C. Mark Vasu, M.D., Grand Rapids.

Several Out-of-State Speakers Scheduled for Coller-Penberthy-Thirlby Meeting July 30-31

Speakers from several midwestern and eastern states will gather in Traverse City July 30 and 31 to participate in the 50th annual Coller-Penberthy-Thirlby Medical Conference at the Park Place Motor Hotel.

They include John W. Williams, M.D., director of transplantation, Johns Hopkins University School of Medicine; George E. Block, M.D., head of the Section of Head and Neck Surgery, University of Chicago School of Medicine; Mark A. Hayes, M.D., professor of surgery, Yale University School of Medicine; W. A. Altemeier, M.D., chairman of the Department of Surgery, University of Cincinnati College of Medicine; Marion S. DeWeese, M.D., chairman, Department of Surgery, University of Missouri Medical Center, and M. M. Musselman, M.D., chairman, Department of Surgery, University of Nebraska College of Medicine.

General Practitioners' Annual Meet June 29-July 1

Special discussions of drug abuse, professional corporations and abortion and contraception will highlight the 24th Annual Postgraduate Clinic of the Michigan Academy of General Practice June 29-July 1 at Boyne Highlands.

The MAGP Congress of Delegates will convene on Sunday, June 28, with the scientific program to begin at 9 a.m. Monday, June 29, and end at noon Wednesday, July 1. The three-day program will consist of individual papers, panel presentations, and a clinic on fractures. In addition, 60 scientific and technical exhibits will supplement the formal program.

Second Class Postage Paid at East Lansing, Mich. and at additional mailing offices.

michigan medicine

MICHIGAN STATE MEDICAL SOCIETY

Published semi-monthly, Trimonthly in December; 25 issues, by the Michigan State Medical Society as its official journal. Second class postage paid at East Lansing, Mich. and at additional mailing offices. Yearly subscription rate, $9.00. Printed in USA. All communications should be addressed to the Publications Committee, Michigan State Medical Society, 120 West Saginaw Street, East Lansing, Michigan 48823. © 1970 Michigan State Medical Society. Phone: Area Code 517, 337-1351.

UNIVERSITY OF CAL
LIBRARY SCH OF MED
THIRD & PARNASSUS AVE
SAN FRANCISCO CAL 94122

Breaking News: Deadline June 23
July 1970, Volume 69, Number 13
Michigan State Medical Society

michigan medicine

Specialties Plan Meetings Sept. 23-24 For MSMS Scientific Sessions In Detroit

Michigan physicians of many specialties will hold important medical meetings during the 1970 MSMS Annual Scientific Session Sept. 23-24 at the Sheraton-Cadillac Hotel, Detroit. Following is a breakdown of the meetings, including speakers and topics where available. All meetings are at the Sheraton-Cadillac, unless otherwise specified.

Wednesday, Sept. 23

Section on Internal Medicine and the Michigan Diabetes Association, 8:30 a.m., Ballroom Annex, Thaddeus S. Danowski, M.D., Pittsburgh.

Section on Urology, 8:30 a.m., Washington Room, Ian M. Thompson, M.D., professor and chairman of urology, University of Missouri, "Extended Bladder Flap Repair and Replacement of the Ureter."

Section on Allergy and Applied Immunology and the Section on Dermatology, 10 a.m., the English Room, J. M. Maas, M.D., Indianapolis, Medical Records Division of the Lilly Research Laboratories, "Dermatological Reactions to the Pill."

Section on Allergy and Applied Immunology, 2 p.m., the English Room, Jordan N. Fink, M.D., associate professor of medicine at Marquette School of Medicine, "Hypersensitivity Pneumonities — A Syndrome of Ever-Increasing Importance."

Section on Plastic Surgery, noon luncheon, Ballroom Annex, John C. Kelleher, M.D., Toledo.

Section on Pediatrics, 2 p.m., Grand Ballroom, John C. Sinclair, M.D., pediatrician, Columbia Medical Center, New York, Thomas Helmrath, M.D., neonatologist, Department of Human Development, Michigan State University, and Robert Gregg, M.D., pediatrician, Wayne State University, "Respiratory Distress." The Michigan Branch, American Academy of Pediatrics, 8 p.m., Grand Ballroom, Doctor Sinclair, "The Evolution of the Incubator."

Section on Gastroenterology, 4 p.m., Ballroom Annex, T. G. Parks, M.Ch., F.R.C.S., Belfast, Ireland, diseases of the Colon.

Section on Otolaryngology, 4 p.m., the Sheraton Room, Cecil W. J. Hart, M.D., Chicago, "An Approach to Dizziness."

The Section on Radiology and the Michigan Radiological Society, 8:30 p.m., the Woodward Room, Henry P. Pendergrass, M.D., Boston, "The Use of Computers in Image Analysis, Radiographic Diagnosis and Reporting."

Other Wednesday scientific meetings will be called by the Section on Physical Medicine at 2 p.m., in the East Room; the Section on Ophthalmology, at 4 p.m. in the East Room; the Section

on Public Health and Preventive Medicine, at 4 p.m. in the Boulevard Room, and the Michigan Branch, American College of Chest Physicians, at 8:30 p.m. in Parlor C and the Normandie Room.

Thursday, Sept. 24

Section on Obstetrics and Gynecology, 9 a.m., the Grand Ballroom, experts on environment, population growth and population controls on panel about "Ecology and Its Relation to Obstetrics-Gynecology."

The Section on Pathology and the Michigan Society of Pathologists, 1:30 p.m., Woodward Room, J. Beach Hazard, M.D., Cleveland – "Lesions of the Thyroid Gland."

Michigan Chapter, American College of Emergency Physicians, "The Treatment of Emergency Cases," 2 p.m., Ambassador Room, Howard Johnson's.

Section on General Practice, 2 p.m., Ballroom Annex, "The Early Diagnosis of Cancer," discussion by panel to include Pap test, suspicious skin lesions and procrastination in the diagnosis and treatment of testicular neoplasms.

Section on Neurology, 2 p.m., the Washington Room, D. Carleton Gajdusek, M.D., Bethesda, "The Activation of Latent Viruses in the Nervous System; The Pathogenesis of Slowly Progressive Degenerative Diseases."

Section on Proctology, 2 p.m., Mason Room, T. G. Parks, M.Ch., F.R.C.S., Belfast, Ireland, "Inflammatory Diseases of the Large Bowel."

Section on Anesthesiology and the Michigan Society of Anesthesiologists, 4 p.m., Ballroom Annex, Ephraim S. Siker, M.D., of Pittsburgh, "Intravenous Agents – Trend or Detour."

Section on Psychiatry, the Michigan Society of Psychiatry and Neurology and the Michigan District Branch of the American Psychiatric Association, 4 p.m., Washington Room, panel discussion of "The Psychological Implications of the Hospitalization of Children." Same group at 8 p.m., Washington Room, Stuart Finch, M.D., Ann Arbor, "The Psychological Implications of Organ Transplanting."

Section on Occupational Medicine and the Michigan Society of Occupational Physicians, 4 p.m., East and West Rooms, Richard C. Murray, computer specialist, American Telephone and Telegraph Company, "A Three-Dimensional Look at Computers in Medicine."

The Section on Orthopedic Surgery and the Michigan Society of Orthopedic Surgeons, 4 p.m., The Normandie Room, Dean C. MacEwen, M.D., Wilmington, Del.

Other Thursday scientific meetings will be called by the Michigan Committee on Trauma, American College of Surgeons, at 2 p.m. in the Boulevard Room; the Section on Thoracic Surgery, at 2 p.m. in the East and West Rooms, and the MSMS Sections on Surgery and Thoracic Surgery, at 4 p.m. in the Grand Ballroom.

Vital Medical Issues Scheduled for 1970 "Current Controversies"

The 1970 "Current Controversies In" series of the annual MSMS meeting will present discussions of relicensure, pollution, and the annual physical.

This series will open Wednesday morning, Sept. 23, with a presentation titled, "Recertification and Relicensure of Physicians – Desirable? Feasible? By Whom?" The main talk will be given by a guest speaker followed by discussants with pro and con views. Scott N. Swisher, M.D., East Lansing, will act as moderator. The meeting will begin at 8:30 a.m. in the Grand Ballroom.

Scheduled to start at the same time is a panel discussion on "The Clinical Aspects of Pollution." Robert A. Green, M.D., Ann Arbor, will act as moderator for a group of five panelists. Topics to be covered will include air and water pollution, pesticides, problems related to the lungs, and the dermatologic aspects of air pollution. This panel discussion will be held in the Woodward Room.

The third talk, "Does the Annual Physical Serve a Useful Purpose?" begins at 10:15 a.m. in the Grand Ballroom. Two guest speakers will present pro and con points of view with Doctor Swisher moderating.

Reminder: It's Unethical To Use Prescription Blanks Bearing Pharmacy Names

The MSMS Judicial Commission wishes to remind all Michigan physicians of its 1964 ruling that is is unethical for physicians to use prescription blanks imprinted with the name of a pharmacy. Any physicians unknowingly writing prescriptions on notepaper imprinted with the name of a pharmacy are urged to obtain new prescription blanks.

Warren F. Tryloff Begins Duties As Director of MSMS

Mr. Tryloff

Mr. Brenneman

Warren F. Tryloff assumed duties in mid-June as director of MSMS, succeeding Hugh W. Brenneman. Mr. Brenneman resigned as director of MSMS to give full time to his candidacy for the Republican nomination for the 24th District (Ingham County) seat in the Michigan Senate.

Mr. Tryloff was appointed by The Council to the directorship, after serving six years as associate executive director under Mr. Brenneman. Mr. Tryloff joined MSMS in 1954 to direct its Detroit office and later became the associate public relations counsel and then assistant to the executive director.

He is secretary of the Michigan Foundation for Medical Education, a member of the American Society of Association Executives and the American Management Association. In addition, Mr. Tryloff is president of the national Professional Convention Management Association.

With his resignation, Mr. Brenneman ended nearly 25 years of service as an executive of MSMS. Mr. Brenneman has been executive director of MSMS for the past six years and prior to that served 18 years as the public service director. He has asked for a leave of absence as director of the Michigan Association of the Professions.

Details about the reorganization of the MSMS staff will be reported in future issues of *Michigan Medicine.*

In Last-Minute Rush, Medical Bills Move Through Legislature

As this issue was being prepared June 23, the Michigan House and Senate were working overtime in order to recess by their June 26 adjournment date. Several medically-related bills were among those receiving attention in the late rush.

The MSMS-sponsored HB 4198, to extend the "Good Samaritan" law to ambulance personnel acting on instructions from physician or nurse while transporting a patient to a medical care facility, had passed the House and was in the Senate Committee on Municipalities and Elections.

Another MSMS-sponsored bill, SB 1312, expands the "confidential" rule to cover medical data of individuals or committees under medical research, and would make such committees immune from subpoena. The bill had passed the Senate and was in the House Committee on Public Health.

HB 4059, a bill to exempt graduates of accredited medical or osteopathic colleges in the U.S. from the Basic Science Exam, had passed the House unanimously and was reported out of the Senate Health, Social Services and Retirement Committee for debate. It is endorsed by MSMS.

Three House bills removing marijuana from the narcotic drug list and reclassifying it as a "dangerous drug" were all passed by the House and sent to the Senate Health, Social Services and Retirement Committee. They are numbered HB 4127, HB 4128 and HB 4239 and are supported by MSMS.

The two bills, HB 4627 and HB 4628, to have the governor appoint the Blue Shield and Blue Cross Boards of Trustees, were passed by the House June 22 and had not yet been assigned to a Senate Committee.

Other key bills — HB 3214, to increase the annual registration for M.D. fees from $5 to $25, and SB 1314, to make many changes in the present podiatry licensing law — had remained stationary since our last report. HB 3214 was still in the House Appropriations Committee and SB 1314 was still in the Senate Appropriations Committee.

MSMS has been closely watching the 1970 amendments, HR 17550, to the federal Social Security Act, which were passed late in May by the U.S. House of Representatives. Testimony by HEW representatives began June 17 in a series of hearings being held by the Senate Finance committee, which now is studying the bill. Public testimony is expected to be heard beginning in mid-July on the amendments.

Miss Mildred Spencer, award-winning medical writer of **The Buffalo Evening News,** presented the 1970 Yates Lecture during the annual Symposium for Medical Writers at Kellogg Center, East Lansing, sponsored by MSMS, the Michigan TB and Respiratory Disease Association, MSU and the Michigan Press Association. She suggested that communities need "medical ombudsmen," to whom individuals may turn for help in solving their medical problems.

A portion of medical writers from newspapers, radio, television and professional publications who attended the symposium give their attention to a morning speaker. Theme of the session was "Health Care in the '70's."

Viewpoints of the health educator, professional organization, public health administrator and private practitioner were all represented in discussions at the annual Symposium for Medical Writers. From left, the speakers were Andrew D. Hunt, Jr., M.D., dean of the MSU College of Human Medicine; Robert Runyon, of the Michigan Hospital Association; Jean Pearson, medical writer for the **Detroit News**, moderator; (latter two partially obscured by the speaker's platform) Maurice S. Reizen, M.D., director of the Michigan Department of Public Health, and D. Bonta Hiscoe, M.D., president-elect of the Ingham County Medical Society.

Scenes of Symposium On Medical Writing

LACTINEX®

LACTINEX

LACTINEX®

TABLETS & GRANULES

- **to help restore and stabilize the intestinal flora**
- **for fever blisters and canker sores of herpetic origin**

Introduced to help reestablish the normal physiology of the intestinal tract in gastrointestinal disturbances[1], particularly diarrheas (including those resulting from antibiotic therapy), Lactinex is also useful for reestablishing the flora following bowel surgery, infant colic, mucous colitis, foul-smelling stools, pruritus ani, flatulence and hives.[2,3,4,5,6]

Lactinex contains a viable mixed culture of both *Lactobacillus acidophilus* and *L. bulgaricus* with the naturally occurring metabolic products produced by these organisms.

No untoward side effects have been reported to date.

Literature on indications and dosage available on request.

HYNSON, WESTCOTT & DUNNING, INC.

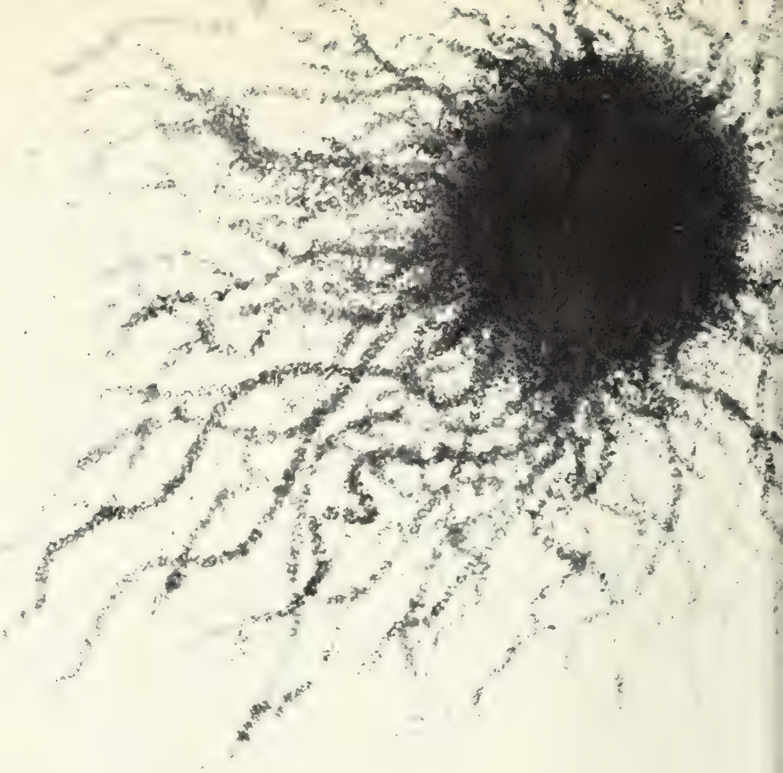
HWD Baltimore, Maryland 21201

(#LX06)

LX

References:

(1) Siver, R. H.: CMD, **21**:109, September 1954. (2) Frykman, H. H.: Minn. Med., **38**:19-27, January 1955. (3) McGivney, J.: Tex. State Jour. Med., **51**:16-18, January 1955. (4) Quehl, T. M.: Jour. of Florida Acad. Gen. Prac., **15**:15-16, October 1965. (5) Weekes, D. J.: NY State Jour. Med., **58**:2672-2673, August 1958. (6) Ellis, S. and Spratt, J. S.: JOUR. AMER. GER. SOC., **18**:410-415, May 1970.



Corticosteroid therapy week after week.

then antibiotic therapy last week.

and monilial overgrowth this week.

For many patients on long-term corticosteroid therapy, the addition of oral antibiotic therapy may trigger monilial overgrowth in the intestine. When you anticipate such a problem, take action with DECLOSTATIN 300. It combines the broad-spectrum potency of demethylchlortetracycline with the antifungal effectiveness of nystatin—it helps avoid monilial take-over. Experience has shown DECLOSTATIN to be highly useful for many women patients; individual culture studies will show exactly where this usefulness may best be applied.

it doesn't let monilia begin where bacteria end.

Declostatin® 300

Demethylchlortetracycline HCl 300 mg and Nystatin 500,000 units Capsule-Shaped Tablets Lederle

Effectiveness: Because its antibacterial component is DECLOMYCIN® Demethylchlortetracycline, DECLOSTATIN should be equally or more effective therapeutically than other tetracyclines in infections caused by tetracycline-sensitive organisms. The antifungal component, nystatin, protects against superinfection by antibiotic-resistant fungal overgrowth (particularly monilia) in the intestinal tract.

Contraindication: History of hypersensitivity to demethylchlortetracycline or nystatin.

Warning: In renal impairment, usual doses may lead to excessive accumulation and liver toxicity. Under such conditions, lower than usual doses are indicated and, if therapy is prolonged, serum level determinations may be advisable. A photodynamic reaction to natural or artificial sunlight has been observed. Small amounts of drug and short exposure may produce an exaggerated sunburn reaction which may range from erythema to severe skin manifestations. In a smaller proportion, photoallergic reactions have been reported. Patients should avoid direct exposure to sunlight and discontinue drug at the first evidence of skin discomfort. Necessary subsequent courses of treatment with tetracyclines should be carefully observed.

Precautions: Overgrowth of nonsusceptible organisms may occur. Constant observation is essential. If new infections appear, appropriate measures should be taken. In infants, increased intracranial pressure with bulging fontanels has been observed. All signs and symptoms have disappeared rapidly upon cessation of treatment.

Side Effects: Gastrointestinal system—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. Skin—maculopapular and erythematous rashes; a rare case of exfoliative dermatitis has been reported. Photosensitivity; onycholysis and discoloration of the nails (rare). Kidney—rise in BUN, apparently dose-related. Transient, reversible, nephrogenic diabetes insipidus with excessive thirst and polyuria (rare). Hypersensitivity reactions—urticaria, angioneurotic edema, anaphylaxis. Teeth—dental staining (yellow-brown) in children of mothers given this drug during the latter half of pregnancy, and in children given the drug during the neonatal period, infancy and early childhood. Enamel hypoplasia has been seen in a few children. If adverse reaction or idiosyncrasy occurs, discontinue medication and institute appropriate therapy. Demethylchlortetracycline may form a stable calcium complex in any bone-forming tissue with no serious harmful effects reported thus far in humans.

Average Adult Daily Dosage: One tablet b.i.d. Should be given 1 hour before or 2 hours after meals, since absorption is impaired by the concomitant administration of high calcium content drugs, foods and some dairy products. Treatment of streptococcal infections should continue for 10 days, even though symptoms have subsided.

Lederle LEDERLE LABORATORIES, A Division of American Cyanamid Company, Pearl River, New York 448-9

michigan medicine

SCIENTIFIC EDITOR
John W. Moses, MD

EXECUTIVE EDITOR
Herbert A. Auer

MANAGING EDITOR
Judith Marr

ASSOCIATE SCIENTIFIC EDITORS
Jason Bodzin, MD
Detroit, House Staff
Frederick J. Cady, Jr., MD
Saginaw, Surgery
Robert M. Daugherty, MD
East Lansing, Basic Science
Harold E. DePree, MD
Kalamazoo, Medicine
Dean C. Elliott, MD
Petoskey, Otolaryngology
Tommy N. Evans, MD
Detroit, Obst.-Gyn.
E. Richard Harrell, MD
Ann Arbor, Dermatology
Dorin L. Hinerman, MD
Ann Arbor, Pathology
Samuel D. Jacobson, MD
Detroit, Medicine
Benjamin Jeffries, MD
Detroit, Psychiatry
Raymond S. Kurtzman, MD
Detroit, Radiology
A. Martin Lerner, MD
Detroit, Medicine
Charles E. Parkinson, MD
Battle Creek, Radiology
John C. Peirce, MD
Grand Rapids, Medicine
Frank H. Power, MD
Traverse City, Surgery
J. G. Turcotte, MD
Ann Arbor, Surgery
Alexander J. Walt, MD
Detroit, Surgery
Park W. Willis, III, MD
Ann Arbor, Medicine
Richard E. Wunsch, MD
Traverse City, Medicine

PUBLICATION COMMITTEE
Brooker L. Masters, MD
Chairman
Robert M. Leitch, MD
William A. LeMire, MD
Don Marshall, MD
Don W. McLean, MD
Milton R. Weed, MD

MICHIGAN MEDICINE is the official organ of the Michigan State Medical Society, published monthly under the direction of the Publication Committee. Published Semi-Monthly, Trimonthly in December; 25 issues, by the Michigan State Medical Society as its official journal. Second class postage paid at East Lansing, Mich. and at additional mailing offices. Yearly subscription rate, $9.00; single copies, 80 cents. Additional postage: Canada, $1.00 per year; Pan-American Union, $2.50 per year; Foreign, $2.50 per year. Printed in USA. All communications relative to manuscripts, advertising, news, exchanges, etc., should be addressed to Publication Committee, Michigan State Medical Society, 120 West Saginaw Street, East Lansing, Michigan 48823. Phone Area Code 517, 337-1351. © 1970 Michigan State Medical Society.

* * *

MICHIGAN MEDICINE welcomes original scientific manuscripts, news items, photographs, features and letters presenting comments on issues. Authors may write to the MSMS Headquarters to obtain detailed instructions for the preparation of scientific papers.

IN THIS ISSUE

This month's cover is designed to draw the attention of Michigan's doctors to the 1970 MSMS Annual Session scheduled Sept. 20-24 at the Sheraton-Cadillac Hotel in Detroit. The Annual Session opens with the House of Delegates meeting Sept. 20-22 and continues with the Scientific Session Sept. 23-24. Be sure to make plans now to attend the meetings.

SCIENTIFIC ARTICLES

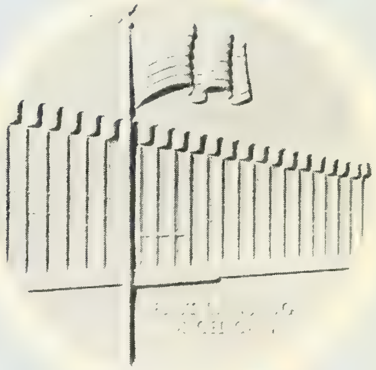
569 The Prevalence of Anemia in Head Start Children; Olaf Mickelsen, Ph.D.; Laura Smail Sims, M.P.H.; Robert P. Boger, Ph.D.; Eileen Earhart, Ph.D.
576 A New and Reliable Method of Closing Median Sternotomy Incisions; R. E. Taber, M.D.; R. C. Coats, M.D.
576 Aorto-Coronary Saphenous Bypass and Vineberg-Sewell Implant in the Treatment of Arteriosclerosis; Walter H. Janke, M.D.; Ali Esfahani, M.D.; Yung-Shik Lee, M.D.
579 Transfer of Nursing Home Patients; John B. Sherman, M.D., M.P.H.
581 Cervical Lymph Node Biopsy; J. G. Lee, M.D.; Christian Helmus, M.D.
585 Candida Parapsilosis Septicemia; Donald L. Bruns, M.D.; Ellsworth R. Littler, M.D.; Jose E. Yanez, M.D.

SPECIAL ARTICLES

577 Some Personal Thoughts Concerning the Detroit Medical Center; A. Martin Lerner, M.D.

OTHER FEATURES

549 breaking news
556 about doctors
558 msms leadership
559 officers' page
560 your opinion please
563 mailbag
583 the viewbox
584 monthly surveillance report
595 welcome
596 msms news
602 mediscene
607 medico-legal
609 ancillary
612 county societies
613 medical care programs
626 in memoriam
630 noted and quoted



MICHIGAN STATE MEDICAL SOCIETY
120 West Saginaw (P.O. Box 152)
East Lansing, Mich. 48823
Area Code 517, 337-1351

about doctors

Doctor Cantor Elected President Of Abdominal Surgeons

Doctor Cantor

Meyer O. Cantor, M.D., Detroit, is new president of the American Society of Abdominal Surgeons, the second largest surgical society in the world, with 10,000 members. A founding member of the society, Doctor Cantor has also been editor of its publication, *The Journal of Abdominal Surgery.*

Doctor Cantor is an attending surgeon at The Grace Hospital, Detroit, and is a prolific writer. He will publish his tenth book by May 1, and will complete and publish two more books by the end of the year. He delivers an average of 12 laboratory papers each year at national and international meetings and has three patents on surgical discoveries.

Vladimir K. Volk, M.D., Saginaw, is the recipient of the Michigan Public Health Association's Distinguished Service award, presented in May at the MPHA annual meeting May 7 in Detroit. Doctor Volk was honored for his leadership in many avenues of the health field, particularly as a career public health officer, leader of both state and national public health associations, and developer of the Adult Day Care Center of the chronic disease program of the Saginaw County Hospital.

F. A. Nickhah, M.D., Ann Arbor, has been elected president of the Midwest Chapter of the American College of Sports Medicine. Doctor Nickhah is one of the founders of the chapter.

William R. Chynoweth, M.D., Battle Creek, retired June 1 at the age of 85. A surgeon and specialist in urology, Doctor Chynoweth celebrated his 50th year in medicine and his 50th year with the military in 1967. Doctor Chynoweth is still a staff member of the Battle Creek Sanitarium and Leila and Community Hospitals in Battle Creek.

Marjorie Peebles-Meyers, M.D., Detroit, is new president of the Michigan Diabetes Association, succeeding Fred W. Whitehouse, M.D., Detroit. Doctor Peebles-Meyers was elected at the association's annual meeting May 5 and was selected by MSMS as Michigan Physician of the Year in 1968. Other new officers of the MDA are Henry D. Kaine, M.D., Franklin, vice president, and Thomas O. Lohr, M.D., Saginaw, a new member of the board of directors.

Benjamin Jeffries, M.D., Harper Woods, has been reappointed by the governor to a term expiring May 8, 1974, on the Advisory Council to the Director of the Michigan Department of Mental Health. Doctor Jeffries is one of four doctors on the eight-member Advisory Council.

John W. Sigler, M.D., Detroit, has been elected president of the Michigan Arthritis Foundation, succeeding Ford Motor Company executive Ray A. Hulce. Doctor Sigler is chief, Division of Rheumatology, Henry Ford Hospital.

Harold L. Upjohn, M.D., Kalamazoo, has resigned as vice president and director of the Laboratory Division of The Upjohn Co., to pursue his interests in the delivery of comprehensive medical care.

Irwin J. Schatz, M.D., Detroit, has been appointed to the editorial board of *CHEST* magazine, formerly *Diseases of the Chest.*

Joseph A. Rinaldo, Jr., M.D., Detroit, takes office this summer as secretary of the American Society for Gastrointestinal Endoscopy.

Ignatios J. Voudoukis, M.D., Detroit, has been elected a member of the Advisory board of the American Association of Foreign Medical Graduates.

Herbert A. Raskin, M.D., Southfield, former chairman of the MSMS Committee on Alcohol and Drug Dependence, is serving as chairman of the Detroit Mayor's Committee for Rehabilitation of Narcotic Addicts and as a consultant for the New York State Narcotics Control Commission. He is also president of the Michigan Association of Law and Psychiatry.

George H. Agate, M.D., Naperville, Ill., formerly with the Michigan Department of Public Health, is now health officer for the northeast regional office of the Illinois State Health Department. His office is in Aurora, Ill.

Fast...long-lasting relief of aches and pains of colds and flu

with the unique timed-release aspirin

Double strength Measurin timed-release aspirin offers a new kind of control for your patients with cold and flu discomforts. In each 10-grain tablet are over 6,000 microscopic reservoirs that release aspirin at a controlled rate—some right away and some later on. This means fast relief of symptoms, followed by hours of comfort. Throughout the day, Measurin gives your patients freedom from a 4-hour aspirin schedule. During the night, its 8-hour dosage schedule holds the promise of sound sleep without awakening to take extra tablets.

For Professional Samples write:
Breon Laboratories Inc.
Sample Fulfillment Division
P.O. Box 141
Fairview, N.J. 07022

BREON BREON LABORATORIES INC.
90 Park Avenue, New York, N.Y. 10016
Subsidiary of Sterling Drug Inc.

MEASURIN®
TIMED-RELEASE ASPIRIN

ECONOMICAL • EFFECTIVE • LONG LASTING PAIN RELIEF

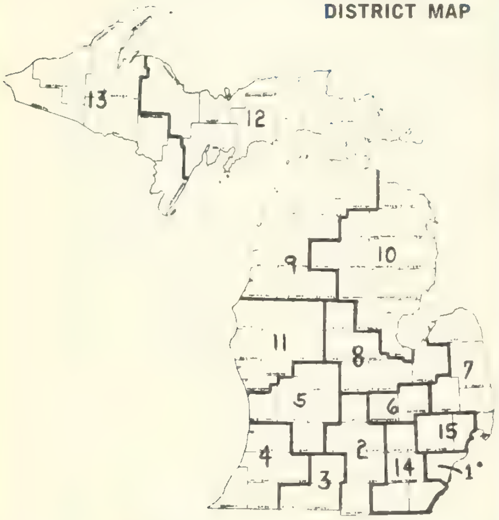
Dosage: 2 tablets followed by 1 or 2 tablets every 8 hours as required, not to exceed 6 tablets in 24 hours. For maximum nighttime pain relief, 2 tablets at bedtime.

Available: Bottles of 12, 36 and 60 tablets.

msms leadership

PRESIDENT	Robert J. Mason, M.D.	Birmingham
PRESIDENT-ELECT	Harold H. Hiscock, M.D.	Flint
SECRETARY	Kenneth H. Johnson, M.D.	Lansing
ASST. SECRETARY	Brooker L. Masters, M.D.	Fremont
TREASURER	John R. Ylvisaker, M.D.	Pontiac
ASST. TREASURER	C. Allen Payne, M.D.	Gd. Rapids
SPEAKER	James B. Blodgett, M.D.	Detroit
VICE-SPEAKER	Vernon V. Bass, M.D.	Saginaw
PAST PRESIDENT	James J. Lightbody, M.D.	Detroit
COUNCIL CHR.	Ross V. Taylor, M.D.	Jackson
VICE-CHAIRMAN	Ralph R. Cooper, M.D.	Detroit

COUNCILOR DISTRICT MAP



First District Councilors: (Wayne County)
Sidney Adler, MD, Detroit
Ralph R. Cooper, MD, Detroit
Don W. McLean, MD, Detroit
Milton R. Weed, MD, Grosse Pointe Park
Robert K. Whiteley, MD, Detroit

Second District Councilor: Ross V. Taylor, MD, Jackson
Counties: Clinton, Eaton, Hillsdale, Ingham, Jackson
Third District Councilor: Robert M. Leitch, MD, Union City
Counties: Branch, Calhoun, St. Joseph
Fourth District Councilor: Don Marshall, MD, Kalamazoo
Counties: Allegan, Berrien, Cass, Kalamazoo, Van Buren
Fifth District Councilor: John R. Pedden, MD, Grand Rapids
Counties: Barry, Ionia-Montcalm, Kent, Ottawa
Sixth District Councilor: Ernest P. Griffin, Jr., MD, Flint
Counties: Genesee, Shiawassee
Seventh District Councilor: John J. Coury, MD, Port Huron
Counties: Huron, Sanilac, Lapeer, St. Clair
Eighth District Councilor: A. Carl Stander, MD, Saginaw
Counties: Gratiot-Isabella-Clare, Midland, Saginaw, Tuscola
Ninth District Councilor: Adam C. McClay, MD, Traverse City
Counties: Grand Traverse-Leelanau-Benzie, Manistee, Northern Michigan (Antrim, Charlevoix, Cheboygan and Emmet combined), Wexford-Missaukee
Tenth District Councilor: Robert C. Prophater, MD, Bay City
Counties: Alpena-Alcona-Presque Isle, Bay-Arenac-Iosco, North Central Counties (Otsego, Montmorency, Crawford, Oscoda, Roscommon, Ogemaw, Gladwin and Kalkaska, combined)
Eleventh District Councilor: Brooker L. Masters, MD, Fremont
Counties: Mason, Mecosta-Osceola-Lake, Muskegon, Newaygo, Oceana
Twelfth District Councilor: William A. LeMire, Sr., MD, Escanaba
Counties: Chippewa-Mackinac, Delta-Schoolcraft, Luce, Marquette-Alger
Thirteenth District Councilor: J. Robert Franck, Jr., MD, Wakefield
Counties: Dickinson-Iron, Gogebic, Houghton-Baraga-Keweenaw, Menominee, Ontonagon
Fourteenth District Councilor: Harold F. Falls, MD, Ann Arbor
Counties: Lenawee, Livingston, Monroe, Washtenaw
Fifteenth District Councilor: Sydney Scher, MD, Mount Clemens
Counties: Macomb, Oakland

EXECUTIVE DIRECTOR
Hugh W. Brenneman....... East Lansing
ASSOCIATE EX. DIR.
Warren F. Tryloff......... East Lansing
GENERAL COUNSEL
Lester P. Dodd................ Detroit
LEGAL COUNSEL
A. Stewart Kerr............... Detroit

ECON. CONSULTANT
Clyde T. Hardwick............ Detroit
SCIENTIFIC EDITOR
John W. Moses, MD........... Detroit
HISTORIAN
Wm. J. Stapleton, Jr., MD...... Detroit
ASS'T HISTORIAN
Wm. M. LeFevre, MD........ Muskegon

Two Predictions About Manpower Shortages

This month I would like to share with you two predictions dealing with aspects of the medical manpower shortage.

Prediction #1 — I predict that more bright, young men are deciding to practice in some of the progressive, smaller communities.

Before and just after World War II, there was a tendency for the eager, young physicians to stay in or near the big medical centers. Many still do. But this pattern is already changing and will continue to change.

Some small communities and suburbs are beginning now to attract both young physicians who are setting up their first practices, and experienced physicians who are moving from big cities to enjoy the living conditions in smaller communities. This mingling of the young with the old elevates the level of medical care in a community and produces a new blend of knowledge, experience and humanism.

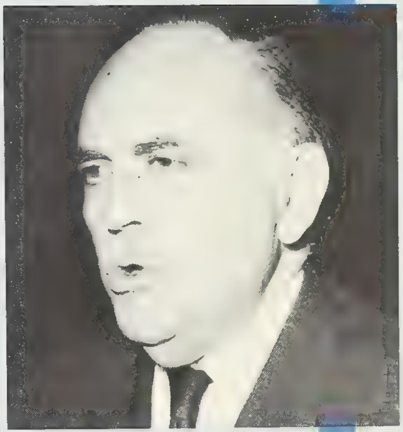
It is interesting, for example, to note that the number of physicians in Ottawa County (Holland and Grand Haven) increased from 61 in 1961 to 83 this year, and that Emmet County (Petoskey) jumped from 27 in 1961 to 48 this year. In Michigan, MSMS and the Michigan Health Council work hard to recruit more doctors.

* * *

Prediction #2 — I predict that the AMA soon will establish several new levels — strata — of physician-support-personnel and will develop procedures for accrediting such new courses. MSMS already is encouraging Western Michigan University to establish a four-year, bachelor's degree program to graduate "assistant physicians" or "physician assistants" as some people prefer to call them.

There is considerable national interest in Michigan because MSMS is the only state association which has endorsed the idea and is actively working to help colleges explore the idea and get courses started. WMU has formed an advisory committee to determine what tasks such a new person would be expected to perform and then to select the courses and clinical training that must be offered to provide such skills and knowledge. MSMS leaders visualize this person working very closely with the physician — in his office, in the hospital, in the clinic, on house calls, etc.

Such programs to train assistant physicians will boom quickly or grow only slowly depending upon the public acceptance of such persons. I personally don't see how the growing population can expect complete care by only the full-fledged physician. There are evidences that Americans are willing to accept care from lesser-trained personnel under the direction of the highly-trained person, such as the real contributions made now by dental technicians, for example, who help the dentist to extend his services.



Robt. J. Mason, M.D.
MSMS President

your opinion please

What suggestion would you offer to make medical education today more relevant to health care needs?

John Cotant, President
1970 Senior Class
WSU School of Medicine

When a young man chooses to make his life that of a physician, he chooses to intimately involve himself with human beings. Paradoxically enough, the first two years of his physician training program are years of shockingly intimate involvement with sheer scientific facts.

It seems reasonable that a part should better represent its whole. Involvement with people and the medical problems of people during the initial years of medical school would vastly contribute to student awareness and enthusiasm concerning health care needs.

Rex Barnes, President
1970 Third-Year Class
MSU College of Human Medicine

Medicine's main objective is the preservation of health. This includes both the prevention of disease, and once disease has occurred, treating appropriately. This leaves a broad field for work and I think most would agree that we are doing reasonably well in our knowledge of the treatment of disease. Our downfall, in my opinion, is our incompetence in distributing our abilities in medicine to all people and preventing disease from occurring in the first place.

Physicians are under fire at the present time because of the many people that are not being treated for their illnesses even though the AMA has stated that health care is a "right of the people." Therefore, our present system is failing in this very basic demand placed upon medicine. I feel it should be one of the top priorities of medical education to produce physicians who are both competent and responsible to develop new programs to meet this need.

Just as distribution of health care should be a top priority, so, too, should such major social problems as pollution and over population. Not all physicians have to become experts in distribution of health care, pollution and over population, but I feel that it is our responsibility to at least become knowledgeable in such issues. This can be done by offering related courses in medical school which discuss the medical aspects of these issues.

If we do this one small thing, I feel medical education will have taken a major step forward in becoming more relevant to present and future health care needs.

David M. Priver, M.D.
SAMA Chapter President
WSU School of Medicine

Modern medicine is faced with a number of serious challenges among which are such things as the physician shortage, an essentially outmoded system of health care delivery, and the public's growing impatience with organized medicine's apparent unwillingness to concern itself in a meaningful way with the health needs of our society as a whole.

In my view, much of the responsibility for these problems lies in our system of educating physicians; a system that has clearly failed to keep pace with modern times. I consider it absolutely essential that we, as physicians concerned about the future of our profession, address ourselves immediately to the problem of *relevance* in medical education, in order to assure the provision of high quality health care to all our citizens.

I have several specific suggestions for improvements in medical curricula. These are by no means exhaustive, but simply represent a few of my own concerns about specific aspects of medical education.

1. Teaching in the pre-clinical sciences must become oriented to medical practice. At present, the teaching in the pre-clinical areas is done primarily by PhDs whose major interest is research, not medical practice. As a result, their lectures and courses are burdensome ventures into the realm of minutiae, and the elements that *are* important

(Continued on Page 563)

I love my family.
I adore this house.
My in-laws are great.
The neighbors are wonderful.

Indications: For use in management of anxiety and tension occurring alone or as accompanying symptom complex to medical and surgical disorders and procedures. Though not a hypnotic, fosters normal sleep through antianxiety and related muscle-relaxant properties

Contraindications: History of sensitivity to meprobamate

Important Precautions. Carefully supervise dose and amounts prescribed, especially for patients prone to overdose themselves. Excessive prolonged use has been reported to result in dependence or habituation in susceptible persons, as alcoholics, ex-addicts, and other severe psychoneurotics After prolonged excessive dosage, reduce dosage gradually to avoid possibly severe withdrawal reactions. Abrupt discontinuance of excessive doses has sometimes resulted in epileptiform seizures

Warn patients of possible reduced alcohol tolerance, with resultant slowing of reaction time and impairment of judgment and coordination

Reduce dose if drowsiness, ataxia or visual disturbance occurs; if persistent, patients should not operate vehicles or dangerous machinery

Side Effects include drowsiness, usually transient, if persistent and associated with ataxia, usually responds to dose reduction, occasionally concomitant CNS stimulants (amphetamine, mephentermine sulfate) are desirable. Allergic or idiosyncratic reactions are rare, but such reactions, sometimes severe, can develop in patients receiving only 1 to 4 doses who have had no previous contact with meprobamate Previous history of allergy may or may not be related to incidence of reactions Mild reactions are characterized by itchy urticarial or erythematous maculopapular rash, generalized or confined to groin. Acute nonthrombocytopenic purpura with cutaneous petechiae, ecchymoses, peripheral edema and fever have been reported. One fatal case of bullous dermatitis following intermittent use of meprobamate with prednisolone has been reported. If allergic reaction occurs, meprobamate should be stopped and not reinstituted. Severe reactions, observed very rarely, include angioneurotic edema, bronchial spasms, fever, fainting spells, hypotensive crises (1 fatal case), anaphylaxis, stomatitis and proctitis (1 case) and hyperthermia. Treat symptomatically as with epinephrine, antihistamine and possibly hydrocortisone. Aplastic anemia (1 fatal case), thrombocytopenic purpura, agranulocytosis and hemolytic anemia have occurred rarely, almost always in presence of known toxic agents. A few cases of leukopenia, usually transient, have been reported on continuous administration

Meprobamate may sometimes precipitate grand mal attacks in patients susceptible to both grand and petit mal. Extremely large doses can produce rhythmic fast activity in the cortical pattern Impairment of accommodation and visual acuity has been reported rarely. After excessive dosage for weeks or months, withdraw gradually (1 or 2 weeks) to avoid recurrence of pretreatment symptoms (insomnia, severe anxiety, anorexia). Abrupt discontinuance of excessive doses has sometimes resulted in vomiting, ataxia, tremors, muscle twitching and epileptiform seizures. Prescribe very cautiously and in small amounts for patients with suicidal tendencies. Suicidal attempts have resulted in coma, shock, vasomotor and respiratory collapse and anuria. Excessive doses have resulted in prompt sleep, reduction of blood pressure, pulse and respiratory rates to basal levels; and occasionally hyperventilation. Treat with immediate gastric lavage and appropriate symptomatic therapy. (CNS stimulants and pressor amines as indicated). Doses above 2400 mg /day are not recommended

Composition. Tablets, 200 mg. and 400 mg meprobamate. Coated Tablets, WYSEALS® EQUANIL (meprobamate) 400 mg. (All tablets also available in REDIPAK® [strip pack], Wyeth.) Continuous-Release Capsules, EQUANIL L-A (meprobamate) 400 mg.

The young homemaker: her underlying anxiety and tension can surface and intensify under the continuous stress of rearing a growing family. Especially when she's confined to the home and its environs so much.

You can help her over the rough spots with reassurance and counsel Equanil can help relieve tension, ease anxiety—with little risk of serious side effects. Time and experience will probably do the rest.

Equanil®
(meprobamate)

Wyeth Laboratories
Philadelphia, Pa.

Photo professionally posed

I'll scream
if I don't get away!

are frequently obscured in the morass of irrelevant facts. I would suggest that teaching in the basic sciences be done wherever possible by practicing MDs, much as is done in the clinical years. For example, I'm sure that a general surgeon would provide a more meaningful course in anatomy than would most anatomists.

2. Laboratories in medical school are almost a complete waste of time and should be largely eliminated. I am sure that they represent a major source of expense and their educational yield is almost nil. The only exceptions to this are those few cases in which labs serve to teach the student a technique that he will later use, such as staining slides or performing a urinalysis.

3. Hopefully, the elimination of laboratories will provide time for instruction in what I consider to be quite relevant, but presently almost totally ignored, areas of study. One of these is the area of comparative systems of health care delivery. It seems clear that unless physicians are well versed in this area they will be largely unable to contribute in a meaningful fashion to needed revisions of our own system. This may lead — and it may already be too late — to the performance of this function by the government, which has already demonstrated its inability to formulate workable health care programs.

4. I would like to see more of an emphasis in the clinical years on the preventative aspects of medicine. This is an area that is sadly neglected at present, and it is indeed unfortunate because it is generally true that there is a far greater expense and effort involved in curing a disease than in attempting to prevent it.

5. Finally, I think that time should be made available at some point in medical school for a comprehensive course in legal medicine. The reasons for this should be obvious to all, and it is a source of amazement to me that such courses have not as yet been instituted except on a very limited scale.

Let me close by saying that I realize that changes are finally being made in medical curricula. They are long overdue, and I am hopeful that they will lead to continual reappraisal of medical education. This is the only way that will avoid the educational stagnation that has affected medical schools over the past half-century.

Insuring Best Delivery Of Mental Health Care

"Your Opinion Please" is a monthly feature in *Michigan Medicine* designed to provide a forum for the views of Michigan physicians on vital issues. Your comments are invited in response to the question asked on this page.

A question is selected each month and interested physicians are urged to send in their reactions. Letters in response to the question for the September issue must be received in the MSMS office by August 1.

The September question will be:

"In view of the increasing complexity and the confusion that exists in the delivery of mental health care services, what suggestions would best insure fullest delivery of services to all people requiring mental health care?"

MAILBAG

Michigan Medicine invites letters of 300 words or less for publication. Communications should be addressed to the Publication Committee, Michigan State Medical Society, 120 West Saginaw, East Lansing, Michigan 48823. Unsigned letters will not be considered; but signed letters will be printed anonymously if the author so requests.

Doctor Esslinger Urges Physicians to React To Current Political Issues

(Editor's Note: The following letter was mailed May 4 to Michigan State Medical Society headquarters. The MSMS Publication Committee invites responses of other Michigan physicians to the proposals of Doctor Esslinger.)

To the Editor:

On this date it has just been announced that four students were killed in a conflict between the National Guard and students on the campus of Kent State University. I have just finished a thirty minute conversation with Dr. Robert Mason, President of the Michigan State Medical Society, and I think it is now time that the members of this Society do express themselves on their feelings regarding the effectiveness of our political situation at this point.

I would suggest that in one of the very near future issues of the Michigan State Medical Society magazine or by mail, that all members of the Michigan State Medical Society be asked to express their feeling as to some of the current political problems that face us today. I might say that I am not a political individual but am truly concerned.

I would think that the questionnaire should be middle of the road and fair and I think we should ask questions such as: Do you think that military force is indicated for the suppression of or control of student riots on campus of major universities and schools where property or personal harm is being inflicted? Do you think that an increase in policing and discipline of students in high schools and elementary schools is in order? Do you think that people should be suspended from congregating in large numbers when there is imminent danger of property or physical damage, such as the recent congregations at New Haven and Harvard?

Now I don't want to sound as though I am a John Bircher, because I am not and I have tried to be liberal. I have a son in South Vietnam who is fighting in the Army, I have a son-in-law who is in the National Guard and a son who is attending Ferris State College and who has participated in peaceful demonstrations. I do feel, however, that the membership of the Michigan State Medical Society should be canvassed on these particular problems and possibly any other political problems that the Society feels fit to quiz them about. Then I think the report of these particular queries should be turned over to our governmental representatives and possibly this type of thing should be repeated on a bi-annual basis for their enlightment.

Sincerely,
John O. Esslinger, M.D.

Doctor Morley Requests Information Of Abortion Cases

(Editor's Note: Doctor Morley's letter arrived too late to appear in MICHIGAN MEDICINE before the legislature had already voted down abortion law reform in its spring session. However, the issue is not dead, and thus we publish the letter as follows:)

To The Editor:

Whereas I appreciate the fact that many physicians do not wish to become involved publicly in regard to the abortion bill, I do feel that we as citizens of the State of Michigan should notify our legislators of our feelings pertaining to this reform. Furthermore, I feel that the Abortion Reform issue is more of a sociologic problem than a medical problem and one for society to resolve; however, I do feel that we as physicians should

(Continued on Page 566)

Brief Summary of Prescribing Information– 9-9/22/69. For complete information consult Official Package Circular.
Indications: Essential hypertension. Use cautiously in patients with renal insufficiency, particularly if they are digitalized.
Contraindications: Anuria, oliguria, active peptic ulceration, ulcerative colitis, severe depression or hypersensitivity to its components contraindicates the use of Salutensin.
Warnings: Small-bowel lesions (obstruction, hemorrhage, perforation and death) have occurred during therapy with enteric-coated formulations containing potassium, with or without thiazides. Such potassium formulations should be used with Salutensin only when indicated and should be discontinued immediately if abdominal pain, distension, nausea, vomiting or gastrointestinal bleeding occurs. Use cautiously, and only when deemed essential, in fertile, pregnant or lactating patients. *Use in Pregnancy:* Thiazides cross the placenta and can cause fetal or neonatal hyperbilirubinemia, thrombocytopenia, altered carbohydrate metabolism and possibly electrolyte disturbances. Fatal reactions may occur with reserpine during electroshock therapy; discontinue Salutensin 2 weeks before such therapy. Increased respiratory secretions, nasal congestion, cyanosis and anorexia may occur in infants born to reserpine-treated mothers.
Precautions: Azotemia, hypochloremia, hyponatremia, hypochloremic alkalosis and hypokaliemia (especially with hepatic cirrhosis and corticosteroid therapy) may occur, particularly with pre-existing vomiting and diarrhea. Potassium loss or protoveratrine A may cause digitalis intoxication. ***Potassium loss responds to potassium-rich foods, potassium chloride or, if necessary, discontinuation of therapy. Stop therapy if protoveratrine A induces digitalis intoxication.*** Serum ammonia elevation may precipitate coma in precomatose hepatic cirrhotics. Discontinue therapy 2 weeks before surgery or if myocardial irritability, progressive azotemia or severe depression occur. Exercise caution in patients with chronic uremia, angina pectoris, coronary thrombosis or extensive cerebral vascular disease *or bronchial asthma* and in those with a history of peptic ulceration or bronchial asthma; in post-sympathectomy patients; in patients on quinidine; and in patients with gallstones, in whom biliary colic may occur. Patients who have diabetes mellitus or who are suspected of being prediabetic should be kept under close observation if treated with this agent.
Adverse Reactions: Hydroflumethiazide: Skin rashes (including exfoliative dermatitis), skin photosensitivity, urticaria, necrotizing angiitis, xanthopsia, granulocytopenia, aplastic anemia, orthostatic hypotension (potentiated with alcohol, barbiturates or narcotics), allergic glomerulonephritis, acute pancreatitis, liver involvement (intrahepatic cholestatic jaundice), purpura plus or minus thrombocytopenia, hyperuricemia, hyperglycemia, glycosuria, malaise, weakness, dizziness, fatigue, paresthesias, muscle cramps, skin rash, epigastric distress, vomiting, diarrhea and constipation. *Reserpine:* Depression, peptic ulceration, diarrhea, Parkinsonism, nasal stuffiness, dryness of the mouth, weight gain, impotence or decreased libido, conjunctival injection, dull sensorium, deafness, glaucoma, uveitis, optic atrophy, and, with overdosage, agitation, insomnia and nightmares. *Protoveratrine A:* Nausea, vomiting, cardiac arrhythmia, prostration, blurring vision, mental confusion, excessive hypotension and bradycardia. (Treat bradycardia with atropine and hypotension with vasopressors.)
Usual Dose: 1 tablet b.i.d.
Supplied: Bottles of 60, 600, and 1000 scored 50 mg. tablets.

Salutensin®
hydroflumethiazide, 50 mg./reserpine, 0.125 mg. protoveratrine A, 0.2 mg.

BRISTOL
BRISTOL LABORATORIES
Division of Bristol-Myers Company
Syracuse, New York 13201

The antihypertensive therapy that is easy to live with.*

When successive blood pressure readings confirm essential hypertension, consider Salutensin for:

Easy-to-live-with control. Gradual reduction of blood pressure leading to decisive, comfortable control is the common clinical response.

*Salutensin is usually well-tolerated (however, serious side effects can occur; see adjacent column for brief summary of prescribing information).

Easy-to-live with dosage. Two tablets a day usually achieves control. One to two tablets a day often maintains control without need for additional antihypertensive agents.

Easy-to-live with cost of therapy. The one to two tablets a day maintenance dose makes Salutensin economical to stay with. Important, because long-term control calls for long-term therapy.

Salutensin®

hydroflumethiazide, 50 mg./reserpine, 0.125 mg. protoveratrine A, 0.2 mg.

act as consultants to the cause since this is a medical issue as well, and we are all interested in preventive medicine.

Being a 'consultant' to the cause, I do feel I should have as much information available to me as possible, so that I can present the medical side of the issue when asked to discuss this problem. I therefore would appreciate it if you would forward to me a summary of significant case histories, etc., or any other opinion you might have on the matter so that I can have this material for future discussion. Obviously the patient's name and physician's name would never be used.

Thank you for this consideration.
George W. Morley, M.D.
Ann Arbor

Flint Health Personnel Express Appreciation For Conference

To the Editor:

I want to express my appreciation to the chairman, Darrell E. Statzer, M.D., Detroit, for presenting the Annual Maternal and Perinatal Health Conference. I express the gratitude of all of us, at Flint Osteopathic Hospital. The result is improved patient care.

We have had nurses and doctors attend each and every session. We pool the knowledge acquired and it does mean a great deal.

Thanks again for inviting us and you may rest assured we are more than willing to contribute our fair share.

Sincerely yours,
Allen B. Corbett, D.O.
Chief—Department of Obstetrics and Gynecology
Flint Osteopathic Hospital

R.N. Has Interest In "New WSU Era"

To the Editor,

I read with great interest your recent article "A New Era for Wayne State University School of Medicine" by Joseph W. Hess, M.D.

May I quote from the article some philosophy which particularly enthused me? ". . . the medical school has an obligation to make sure that qualified students from disadvantaged minority groups are not excluded from medical school by criteria which are biased against them."

I was also happy to see that "needed remedial work prior to entry and additional assistance" is provided.

I am a member of the following minority groups:

a. females
b. registered nurses
c. mothers
d. the over thirties

Where do I apply?

Sincerely yours,
Gloria F. Leach, R.N.
Detroit

(Editor's Note: Queries to Michigan's three medical schools disclosed the following statistics: Wayne State University has 53 women enrolled in all four medical classes; the University of Michigan has 79 women enrolled and Michigan State University has 10 women enrolled in its three medical school classes. An increase in women medical students over the past five years is reported at both Wayne State University and the University of Michigan.)

Ben Stratton Praises Recent Journal Article

To the Editor:

I recently read the article, "Consent — A Problem in Medicine" in the February, 1970 issue of *Michigan Medicine*, by Martin Lloyd Norton, M.D., Detroit. This is certainly a most timely subject in the area of medical malpractice insurance.

The author is to be complimented by the thorough treatment he has given this subject and he has also made this a most interesting and readable article. It is encouraging when a person with his medical and legal qualifications will take the time to research and write regarding a situation which requires action by all concerned — physicians, attorneys, and those involved with the insuring of this risk.

I am sending a copy of the article to the carrier we represent in the malpractice field. I am certain they will find this an important reference for retention in their law library.

Sincerely,
Ben P. Stratton
Stratton Insurance Agency
Lansing

Mylanta®
24 million hours a day.

Through the day, every day,
ulcer patients take
one million doses of Mylanta
for relief of ulcer pain.

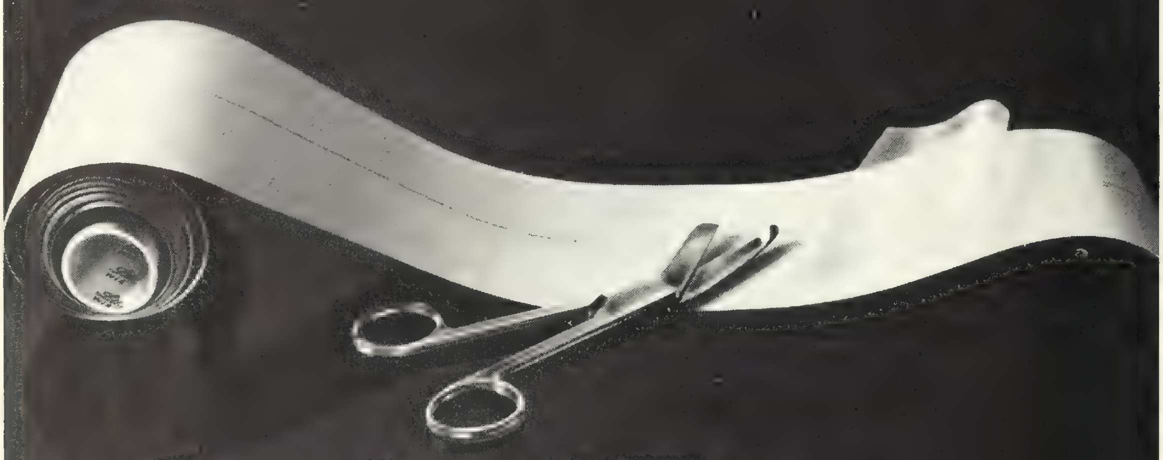
Mylanta®
LIQUID/TABLETS
aluminum and magnesium hydroxides plus simethicone

Good taste = patient acceptance
Relieves G.I. gas distress*
Non-constipating

*with the defoaming action of simethicone

Stuart
PHARMACEUTICALS Pasadena, Calif. 91109
Division of Atlas Chemical Industries, Inc., Wilmington, Del. 19899

Now
available for your
prescribing
needs



Cordran® Tape
FlurandrenolideTape (4 mcg. per sq. cm.)

Additional information available upon request • Eli Lilly and Company, Indianapolis, Indiana 46206

Lilly

The Prevalence of Anemia In Head Start Children

By Olaf Mickelsen, Ph.D.
Laura Smail Sims, M.P.H.
Robert P. Boger, Ph.D.
Eileen Earhart, Ph.D.
All of East Lansing

Recent concern about the status of the disadvantaged in America has produced increasing reports of malnutrition among certain segments of the population.

The social issue receiving much attention in Washington this year is the prevalence of hunger and malnutrition in the United States. Consequently, information on the nutritional condition of the low income groups in our country has appeared in several Congressional Committee reports. Such reports are entitled, "Hunger Study" *(Comm. on Agric., House of Representatives, June 11, 1968),* "Hunger and Malnutrition in America" *(Subcomm. on Employment, Manpower and Poverty, U. S. Senate, July 11-12, 1967),* "Hunger and Malnutrition in the United States" *(ibid, May 23, 29, June 12, 14, 1968),* and "Nutrition and Human Needs" *(Select Comm. on Nutrition and Human Needs, U. S. Senate, Part I: Dec. 17, 18, 19, 1968; Part II: Jan 8, 9, 10, 1969, and Part III: Jan. 22, 23, 27, 28, 1969).*

In 1968, a federally supported program entitled the "National Nutrition Survey" was initiated in ten states. These surveys will primarily assess the nutritional status of people in low income areas (1). One of these surveys [in Texas] has been completed and the preliminary report published (2). Other studies are currently being conducted on the premise that if nutritional deficiencies exist, the incidence will be greatest among the poor (3). Such surveys are necessary since precise data on the nutritional state of the lowest economic strata of our society are nonexistent.

Although there are many causes of anemia, the level of hemoglobin is frequently used as one indication of the intake of those nutrients required for blood formation. There are a number of reports on the incidence of anemia. Current medical literature commonly describes anemia as a "significant public health problem among infants and young children" (4). In fact, some even regard this syndrome as the *most* common deficiency disease in infancy and childhood today (5).

Many accept the idea that nutritional anemia is particularly prevalent among "low income" or "disadvantaged" people. Klipstein states, "Anemia is more common among persons from a low socioeconomic setting and among non-whites than in the general population. . . . This is particularly true for children . . . in whom the demand for iron is greater than normal" (6). Hillman and Smith suggest that low hemoglobin levels occur more frequently in the less favored economic groups. They attribute this to poor dietary patterns, resulting from ignorance and apathy, as well as to "marginal availability of essential nutrients" (7).

Project Head Start was initiated by Title II-A of the Economic Opportunity Act of 1964, and was funded by the Office of Economic Opportunity as part of the Community Action Program. Designed as a means of social intervention to help children from culturally and educationally deprived families, the program contains five major components: health, nutrition, education, parent involvement, and social and psychological services (8).

During the first year of the Head Start program, mass screening of 7,000 children, 3 to 6 years of

scientific papers

Doctor Mickelsen and Mrs. Sims are with the Department of Foods and Nutrition, and Doctor Boger and Doctor Earhart are with the Head Start Evaluation and Research Center, Michigan State University, East Lansing.

age, failed to reveal the expected high incidence of anemia. The authors comment, "generalizations concerning the national incidence of nutritional anemia in preschool children on the basis of isolated local studies may not be warranted . . . however, regional studies may reveal local needs" (9).

A major objective of this paper is to present an analysis of data describing the prevalence of anemia among Head Start children in Pontiac, Michigan.

Procedure

Hemoglobin and hematocrit determinations were performed on 77 children, 4 to 6 years of age, enrolled in five classes of the Pontiac, Michigan*, Head Start Program. This sample accounts for approximately one-third of the children enrolled in the total program in that city. These five classes were participating in a curriculum intervention and evaluation project conducted by the Head Start Evaluation and Research Center at Michigan State University. Because each child met the criteria of eligibility for admission into the program, the sample is assumed to be representative of the "disadvantaged" segment of the population.

One month after the program started, blood samples were collected from the 77 children enrolled; these are the "pre" data. A second series of blood samples was obtained from 52 of these children approximately six months later; they are the "post" data. Twenty-five children unaccounted for in the post data either had dropped out of the program or blood samples were not collected from them for sundry reasons.

Finger prick blood samples were collected from each child for duplicate hemoglobin determinations and for duplicate microhematocrit determinations. Hemoglobin was determined by the cyanmethemoglobin procedure with a Fisher hemophotometer. On each occasion the hemoglobin procedure was standardized using a commercial standard, Hycel[1]. Microhematocrit determinations were performed using an International centrifuge. This procedure was repeated if the results were inconsistent with the hemoglobin values. Approximately one hour intervened between obtaining blood samples and final analyses.

Heights and weights were obtained for each child twice during the course of the program by a registered nurse assigned to the Head Start program. Body weights were recorded to the nearest 0.25 pound using a balance beam scale. Heights, determined by using a cross bar on the scale, were recorded in 0.25 inch increments. Both measurements were taken on the same days as blood samples were collected.

The Problem of Blood Standards

A major problem in translating hemoglobin levels into clinical categories is the absence of an acceptable standard for identifying anemic individuals. Many "standards" have been proposed for describing normal blood values for individuals of various age groups. However, there is so much variation in these suggested values that the incidence of anemia as judged by one standard may be very different from that based on another.

The variation in standards can be shown by comparing only a few of the more commonly used criteria. One of the most widely used standards for nutrition surveys lists the following values for 3- to 12-year old children (10):

	Deficient	**Low**	**Acceptable**	**High**
Hemoglobin (gm/100ml)	<10.0	10.0-10.9	11.0-12.4	≤12.5
Hematocrit (% PCV)[2]	<30.0	30.0-33.9	34.0-36.9	≤37.0

Only a few standards specifically set levels of hemoglobin indicative of anemia. This has been done by the American Medical Association which considers anemia to exist in the 6-month to 4-year-old group when the hemoglobin level is below 11 gm/100ml of blood or when the hematocrit level is below 33% (11). The Children's Bureau Publication, "Suggested Guidelines for Evaluation of the Nutritional Status Preschool Children," proposes that hemoglobin values of less than 10.0 gm/100ml and/or hematocrits less than 30% be considered indicative of anemia (12). Another Children's Bureau publication arbitrarily defines anemia in infants and preschool children as "a state in which the concentration of hemoglobin is less than 10 gm/100ml" (13).

One of the major difficulties encountered in the comparison of blood standards is the connotation imparted to the terms used. Values often designated as "normal" are misleading; the reader is uninformed as to whether this level is the most commonly occurring, the mathematical average, or that which is desired or optimal. Sources listing "normal" blood values usually give higher levels than those indicative of anemia.

One of the standard textbooks of pediatrics (Holt's, 14) gives "averages for optimal conditions" as:

Age	**Hemoglobin (gm/100ml)**	**Hematocrit (% PCV)**
3-4 years	13.2 ± 0.8	40 ± 3
4-5 years	13.4 ± 1.0	40 ± 2

---

* According to the 1960 Census, the population of Pontiac, Michigan (25 miles north of Detroit) was 82,233. Incomes below $3,000 annually were reported by 16% of the families; 45% of employed persons were engaged in manufacturing industries.

[1] Purchased from Scientific Products, Allen Park, Mich.

[2] PCV = packed cell volume.

Pontiac, Michigan "Head Start" Data:	Hemoglobin gm/100ml			Hematocrit % PCV			
	%<10	%<11	Mean±S.D.	%<30	%<31	%≤33	Mean±S.D.
"Pre": n=77	0	1.3	12.5±0.6	0	0	5.3	36.75±2.0
"Post": n=52	0	1.9	12.8±0.8	0	0	7.8	37.80±2.5
Pearson, **et al**[9]:							
Total N=7000							36.32±2.8
Chicago, n=3480					4.5		
Gainesville, n= 477					1.7		
Jacksonville, n= 622					2.8		
Augusta, n= 415					7.7		
Houston, n=1750					0.6		
Kravitz[25]: n=2319	8.5	31.6					
Stine, **et al**[19]:							
Total N= 768						Negro: 20 White: 5	35.97±3.32
All non-white, n= 578							35.64±3.39
All white, n= 190							36.96±2.39
All males, n= 371							35.75±3.25
All females, n= 397							36.17±3.18
White males, n= 94							37.01±2.22
White females, n= 96							36.91±2.54
Non-white males, n= 277							35.32±3.43
Non-white females, n= 301							35.93±3.32
Kripke and VanFossen cited in Filer[4]: n= 81		27.5					
Kerry, **et al**[27]:							
"low" income, n= 20			12.1±2.9				38.9±10.1
"high" income, n= 20			12.0±2.8				38.8± 9.4
Owen, **et al**[3]:							
Group A (lowest income)	24		10.6±1.4				
Other groups	12		11.2±1.2				
Haughton[31]: n= 103	3.8						
Hutcheson[32]: Total N=5126				4.3	11.8	25.9	
White, n=3968				4.1	9.2	23.6	
Non-white, n=1158				5.0	15.5	33.8	
Public Health Service[21]:							
Negro children under 7 years of age, n= 169			11.3				
Goldsmith & Unglaub[18]:							
Total N= 493	11.2	43.9	11.14±1.1	1.0		5.4	37.2±2.8
Males, n= 275			11.15±1.1				37.2±2.9
Females, n= 218			11.13±1.1				37.2±2.8
Unglaub[26]: Total, N= 499	11.2	40.8					

Table 1

Prevalence of Children with Low Hemoglobin and Hematocrit Values in the Pontiac, Michigan, Head Start Program with Selected Data from the Literature. (Mean hemoglobin and hematocrit values are also listed.)

Another widely used pediatrics text (Nelson, 15) lists the "normal" hemoglobin value for 4-year-old children as 13.1 gm/100ml. The "high" values for children from 3 months of age to adolescence, listed in the ICNND nutrition survey manual, are considered "normal" by one pediatrician (5).

Guest, *et al*, propose 12.5 gm/100 ml as a "desirable" hemoglobin value for children between three months and adolescence (16). Smith considers the normal hemoglobin level for children to be between 12.5 and 13.5 gm/100 ml (17).

Because of the wide variation in accepted standards, data for this study were recorded as absolute hemoglobin and hematocrit values.

Results

When compared to the standards commonly used in nutritional surveys (10), only one child on both occasions had a hemoglobin value in the "low" category, i.e., below 11 gm/100ml (**Table 1**). All others had "acceptable" or "high" hemoglobin values. The latter category had as its lower limit a hemoglobin level of 12.5 gm/100ml. Over 60% of the children had levels above that value. This was true for the determinations made early in the school year as well as those toward the end of the year.

Since nearly one-third of the children in the original group were unavailable for the second set

Table 2

Hemoglobin and Hematocrit Values for Pontiac, Michigan, Head Start Children

HEMOGLOBIN (gm/100 ml)	Deficient[a] <10.0		Low 10.0 - 10.9		Acceptable 11.0 - 12.4		High ≥12.5		MEAN	RANGE
	No.	%	No.	%	No.	%	No.	%		
"Pre" Data:										
Boys	0	0	1[b]	2.2	16	34.8	29	63.0	12.5 ± 0.65[c]	10.1-14.0
Girls	0	0	0	0	12	38.7	19	61.3	12.5 ± 0.61	11.2-13.7
Total (n=77)	0	0	1	1.3	28	36.3	48	62.4	12.5 ± 0.63	10.1-14.0
"Post" Data:										
Boys	0	0	1[b]	3.2	9	29.0	21	67.7[d]	12.9 ± 0.88	10.6-14.4
Girls	0	0	0	0	4	19.1	17	80.9	12.8 ± 0.68	11.0-14.1
Total (n=52)	0	0	1	1.9	13	25.0	38	73.1	12.8 ± 0.78	10.6-14.4
HEMATOCRIT (PCV - %)	Deficient <30.0		Low 30.0 - 33.9		Acceptable 34.0 - 36.9		High >37.0		MEAN	RANGE
	No.	%	No.	%	No.	%	No.	%		
"Pre" Data:										
Boys	0	0	2	4.0	21	46.7	22	49.3	36.7 ± 2.00	33 - 41
Girls	0	0	2	6.7	10	33.3	18	60.0	37.0 ± 2.00	32 - 40
Total[e] (n=75)	0	0	4	5.3	31	41.3	40	53.3	36.8 ± 2.00	32 - 41
"Post" Data:										
Boys	0	0	2	6.4	6	19.4	23	74.2	38.0 ± 2.55	32 - 43
Girls	0	0	2	10.0	4	20.0	14	70.0	37.6 ± 2.54	32 - 41
Total (n=51)	0	0	4	7.8	10	19.6	37	72.5	37.8 ± 2.54	32 - 43

[a] Standards: ICNND, Manual for Nutrition Surveys, 1963, p. 235[10].

[b] Same Child.

[c] Standard Deviation.

[d] Rounding Error.

[e] Hematocrit data were unavailable for several children for whom hemoglobin data were collected.

of determinations, their original hemoglobin values were examined separately. Of the 15 boys and 10 girls for whom there was only the first blood value, the average hemoglobin level was 12.6 gm/100ml, with a range from 11.2 to 14.0 gm/100ml. This value is comparable to the mean for the entire group, 12.5 gm/100ml; the range was 10.1 to 14.0 gm/100ml. (**Table 2**).

The Manual for Nutrition Surveys (10) suggests that children with hemoglobin levels below 11 gm/100ml be considered anemic. On this basis, 1.3% of the "pre" and 1.9% of the "post" determinations were indicative of anemia. However, if a hematocrit value less than 33% is used as an indication of anemia, 5.3% of the children after the first determination, and 7.8% of the children after the second could be considered anemic. That the hematocrit determinations indicated a greater prevalence of anemia than did the hemoglobin values was also reported by McGanity, who noted that in the Texas survey of nutritional status, the "percent of low values for hematocrit was severalfold greater than those for hemoglobin" (2). In contrast, Goldsmith and Unglaub, in comparing blood data with guidelines using the hemoglobin level, mean corpuscular hemoglobin, and hematocrit, state that "use of the hematocrit as the criterion of reference gives the lowest prevalence figures" (18). They further believe "hemoglobin values are probably of the greatest significance in determining the presence of clinically definable anemia."

This discrepancy between values for both hemoglobin and hematocrit is more apparent at the lower end of the scale. In this sample of Head Start children, the boy with the lowest hemoglobin value (10.1 gm/100ml) had a hematocrit value of 33%, while the girl with the lowest hematocrit value (32%) had a hemoglobin level of 11.2 gm/100ml. For the higher levels, the values for hemoglobin and hematocrit correlated more closely.

The 21 girls on whom both blood determinations were made showed an increase in hemoglobin level from an average of 12.5 for the first tests to 12.8 gm/100ml for the second. The corresponding hematocrit values were 37.0 and 37.6% respectively. The 31 boys, from whom blood samples were secured on both occasions, showed an average change in hemoglobin level from 12.5 in the fall to 12.9 gm/100ml in the spring. Hematocrit values were 36.7 and 38.0%, respectively. For those children who showed changes in hemoglobin values between the first and second determinations (**Table 3**), the maximum increase was from 11.5 to 13.6 gm/100ml, which corresponded to an increase in hematocrit from 34% to 40%. The maximum decrease was from 13 to 12 gm/100ml hemoglobin, which likewise corresponded to a drop in hematocrit from 39% to 35%.

Racial differences in blood values were noted (**Table 4**). On both occasions, approximately 80%

Table 3

Children Showing Changes in Hemoglobin Values Between the First and Second Determinations

Hemoglobin Values	Boys		Girls		Total	
	No.	%	No.	%	No.	%
Increase ≥ 0.5 gm/100 ml.	12	38.7	9	42.9	21	40.4
Decrease ≥ 0.5 gm/100 ml.	5	16.1	2	9.5	7	13.5

of the children tested were Negro. Although the differences noted between the values for the Negro and white children are not statistically significant, the black children had lower hemoglobin and hematocrit values than the white. Stine, *et al,* (19) indicated a similar occurrence in their study of preschool children in the District of Columbia. Owen has noted that "it would appear that iron deficiency is at least twice as prevalent among Negro as among white children" (20).

In 1949, a study conducted in Ferndale, Michigan (a northern suburb of Detroit, approximately 15 miles southeast of Pontiac) also indicated lower hemoglobin levels for Negroes as compared with white persons in similar age groups (21). While this racial difference seems to be consistently maintained, causal factors remain unexplained.

To more completely assess the health status of these children, blood data were compared to height changes. Height was chosen since it is influenced to a lesser extent by many extraneous factors than is weight. The data were compared with two standards of height for age: the Stuart-Meredith percentile standards (22) and the Iowa growth charts (23). The Stuart-Meredith tables give heights for age in percentiles. The Iowa growth charts provide a mean height-age curve and indicate standard deviations therefrom. Data for both of these standards were based on measurements of white children in Iowa; however, a recent publication indicated that measurements of Negro children in the District of Columbia were similar to those figures listed in the above standards (24).

Using the Stuart-Meredith percentile standards of height for age (17), Head Start children in Pontiac were well within the acceptable ranges of "normal" **(Table 5)**.

When the heights of these children were compared with the Iowa height-age curves (23), all were again well within the range for normal. The initial data indicated that the 9 boys with high hemoglobin levels were 0.3% above the mean for height, while the 6 girls were 0.4% less than the mean. The one boy having a low hemoglobin level was 0.7% below the mean. The follow-up data showed that the 13 boys having hemoglobin levels greater than 13 gm/100ml were 1.4% above the mean of the Iowa growth standards of height for age, while the 8 girls with similarly high hemoglobin values were 2% below the mean height for age. One boy with a hemoglobin level less than 11 gm/100ml was 0.7% below the mean, while the girl with a hemoglobin level less than 11 gm/100ml was 4.1% above the mean height for age. These data suggest that this group of Head Start children compared favorably with accepted standards of growth.

Although no significant relationship existed between the children's status on the growth curves and the blood data, a relationship is suggested between hemoglobin levels and incremental gains in height. The 13 boys with high hemoglobin levels on both occasions increased 0.8 inches in height in the interim. The 8 girls with hemoglobin levels above 13 gm/100ml increased in height by approximately 0.5 inch. However, the boy and girl having "low" hemoglobin values (less than or equal to 11 gm/100ml) did not gain in height.

Discussion

Recently many investigators have pointed to the prevalence of anemia, especially among low income groups, as one index of their poor nutritional status. Since children reportedly have a high incidence of anemia, their condition has received most attention. Studies have suggested a "generally high" incidence of anemia among Head Start children (20). In 1965, 8.1% of the children in the Chicago Head Start program were reported to have hemoglobin values below 10 gm/100ml (and more than 30% had hemoglobin levels below 11 gm/100ml (25). Pearson, *et al,* reported that the average hematocrit level for nearly 7,000 Head Start children in Chicago, Gainesville, Houston, Augusta, and Jacksonville was 36.3%. These authors indicated that 1

Table 4

Racial Differences in Hemoglobin Values (gm/100ml)

	Negro		White*	
	Pre	Post	Pre	Post
Male	(n=37) 12.5 ± 0.6	(n=25) 12.8 ± 0.9	(n=9) 12.6 ± 0.7	(n=6) 13.2 ± 0.5
Female	(n=25) 12.4 ± 0.6	(n=19) 12.8 ± 0.7	(n=6) 12.8 ± 0.4	(n=2) 13.0 ± 0.6

* Includes 2 Mexican-American children.

Table 5

Hemoglobin Values in Relation to Mean Percentile Standards of Height for Age*

	Boys		Girls	
	No.	Mean Percentile	No.	Mean Percentile
"Pre" Data:				
Hemoglobin ≥ 13 gm/100 ml	9	55	6	38
≤ 11 gm/100 ml	1 **	45	—	—
"Post" Data:				
Hemoglobin ≥ 13 gm/100 ml	13	57	8	47
≤ 11 gm/100 ml	1 **	50	1	89

* Data tabulated using Stuart-Meredith percentile standards of height for age.[22]

** Same Child.

to 8% of children four to six years of age were anemic on the basis of a hematocrit value below 31% (9).

Regional differences are apparent in the prevalence of anemia. Pearson, *èt al,* indicated that the incidence of significant anemia showed considerable variation from city to city (9). They found that children in Chicago and Augusta had an increased frequency of anemia, when compared with figures from Gainesville, Houston, and Jacksonville. In the New Orleans Head Start program in 1968, Goldsmith and Unglaub reported that 11.2% of the children had hemoglobin levels less than 10 gm/100ml (18). In 1969, Unglaub again reported that 11.2% of the children had hemoglobin values less than 10 gm/100ml, while 40.8% had levels less than 11 gm/100ml (26). These figures contrast with the relatively low numbers with similar hemoglobin values found in the Pontiac, Michigan, Head Start program. Various factors, such as the iron content of the soil, methods of food preparation, or local dietary practices, might account for this noted geographic variability.

Hemoglobin values are commonly correlated with income data. In Mississippi, Owen, *et al,* found that 24% of preschool children from the lowest socioeconomic group (annual per capita income less than $500) had hemoglobin values less than 10 gm/100ml, compared with a total of 12% of children from the higher income groups (3). The mean hemoglobin level for the lowest income group was 10.6 gm/100ml, and for the higher income groups 11.2 gm/100ml, a difference considered to be significant. Kerrey, *et al,* **(Table 1)**, in contrast to the previous studies, found no differences in hemoglobin levels between preschool children from low-income families when compared with children from higher income families (27).

The incidence of iron-deficiency anemia is reported to reach a peak in infants 12 to 17 months of age and decreases thereafter until the condition is overcome between 3 and 6 years of age (28). Owen has stated that "the same trend of decreasing incidence of anemia with increasing age was noted in low income Mississippi children" (3). "By the age of 3½ years, anemia is relatively rare, which suggests that, because of the slow rate of growth in the preschool period, the child is able gradually to accumulate enough iron to meet his needs" (29).

For approximately 22,000 children between birth and 20 years of age registered in the Children and Youth Projects, values less than 10.0 gm/100ml were relatively frequent in children under 3 years of age but much less frequent in older children (30). The percentages of children with hemoglobin levels below 10 gm/100ml were: 13.6% for infants to 6 months of age, 22.1% for infants 6 months to 1 year, 28.5% for children 1 to 2 years and 9.2% for children 2 to 3 years of age. Since hemoglobin levels seem to improve with age, it is possible that some of the Pontiac Head Start children may have had low hemoglobin levels at an earlier age.

The data presented from the Pontiac Head Start study are quite comparable to those from other studies throughout the country **(Table 1)**. Whether one chooses to interpret the findings as suggestive of the extensive prevalence of anemia in these children will depend on the standard chosen. On the basis of hemoglobin and height measurements, most of the Head Start children examined in Pontiac, Michigan appeared to be normal.

Summary

Hemoglobin and hematocrit values and height measurements are presented for 77 children enrolled in the Pontiac, Michigan Head Start program. On the basis of these findings, the mean hemoglobin level of all subjects for blood collected in the fall shortly after the program started was 12.5 gm/100ml, while the mean value for blood collected in the following spring was 12.8 gm/100ml. Comparable hematocrit values were 36.8% and 37.8% respectively. Over 60% of the children in this study were in the "high" range of values for both parameters according to standards commonly used in nutritional surveys (10). Comparisons of blood and height for age data with accepted standards (22, 23) revealed that Head Start children studied in Pontiac appeared to be well within acceptable ranges of normal.

Acknowledgements

We wish to express our thanks to Dr. William R. Dito, Mr. William Bovian, Mrs. Arden Wilson, the staff of the Pathology Department, Pontiac General Hospital, Pontiac, Michigan, and to Mrs. Barbara Perkins, R.N., Head Start nurse, Pontiac, Michigan, for their assistance in making this study possible. Mrs. Perkins generously gave of her time to bring in those children who were absent at the time of the initial examination so that complete data could be obtained.

References

1. Schaefer, A. E. and O. C. Johnson. Are we well fed? The search for the answer. *Nutrition Today* 4:3, Spring, 1969.
2. McGanity, W. J. Nutrition survey in Texas. *Texas Medicine* 65:40, March, 1969.
3. Owen, G. M., P. J. Garry, K. M. Kram, C. E. Nelsen and J. M. Montalvo. Nutritional status of Mississippi preschool children: a pilot study. *Am. J. Clin. Nutr.* 22:1444, 1969.
4. Filer, L. J. The USA today — Is it free of public health nutrition problems? Anemia. *Am. J. Pub. Health* 59:327, 1969.
5. Jacobs, I. Iron deficiency anemia in infancy and childhood. *Gen. Prac.* 21:93, 1960.
6. Klipstein, F. A. Nutritional anemia among America's poor. *Ann. Intern. Med.* 68:1125, 1968.
7. Hillman, R. W. and H. S. Smith. Hemoglobin patterns in low-income families. *Pub. Health Reports* 83:61, 1968.
8. *Head Start — A Community Action Program.* Office of Economic Opportunity, Washington, D. C. 20506.
9. Pearson, H. A., I. Abrams, D. J. Fernbach, S. P. Gyland and D. A. Hahn. Anemia in preschool children in the United States of America. *Pediat. Res.* 1:169, 1967.
10. Interdepartmental Committee on Nutrition for National Defense. *Manual for Nutrition Surveys.* (2nd Ed.) Bethesda, Md.: National Institutes of Health. 1963, p. 24.
11. Committee on Iron Deficiency. Iron deficiency in the United States. *J. Am. Med. Assoc.* 203:407, 1968.
12. U. S. Department of Health, Education, and Welfare, Children's Bureau. "Suggested Guidelines for Evaluation of Nutritional Status of Preschool Children." 1966, rev. 1967, p. 24.
13. U. S. Department of Health, Education, and Welfare, Children's Bureau. "Prevention of Iron-deficiency Anemia in Infants and Children of Preschool Age." 1967, p. 1.
14. Holt, L. E., R. McIntosh and H. L. Barnett. *Pediatrics.* (13th Ed.) New York: Appleton-Century-Crofts, Inc., 1962, pp. 592-593.
15. Nelson, W. E. (Ed.) *Textbook of Pediatrics.* (8th Ed.) Philadelphia: W. B. Saunders Co., 1964, p. 1007.
16. Guest, G. M., E. W. Brown and M. E. Lahey. Normal blood values in infancy and childhood. *Pediat. Clin. N. Am.* 93:362, 1957.
17. Smith, C. H. *Blood Diseases of Infancy and Childhood.* St. Louis: C. V. Mosby Co., (2nd Ed.), 1966, p. 204.
18. Goldsmith, G. A. and W. G. Unglaub. Progress Report, Office of Economic Opportunity, Period July 1, 1968 — September 30, 1968, Appendix III. (Unpublished).
19. Stine, O. C., J. B. Saratsiotis and O. F. Furno. Appraising the health of culturally deprived children. *Am. J. Clin. Nutr.* 20:1084, 1967.
20. Select Comm. on Nutrition and Human Needs, U. S. Senate: *Nutrition and Human Needs.* Part II: USDA, HEW, and OEO officials. (Jan. 8, 9, 10, 1969) pp. 604; 585; 594-597.
21. Nutrition and Program Analysis Branches, Public Health Service: The nutritional status of Negroes. *J. Negro Educ.* 18:291, 1949.
22. Stuart, H. C. and H. V. Meredith. Percentile standards. As published in: Watson, E. H. and G. H. Lowry. *Growth and Development of Children.* (5th Ed.) Chicago: Yearbook Med. Publ. Inc., 1967, pp. 89-92.
23. Jackson, R. L. and H. G. Kelly. Growth charts for use in pediatric practice. *J. Pediat.* 27:215, 1945.
24. Verghese, K. P., R. B. Scott, G. Teixeira and A. D. Ferguson. Physical growth of North American Negro children. *Pediatrics* 44:243, 1969.
25. Kravitz, H. Results of "Operation Head Start" in Chicago, Ill., *Med. J.* 129:590, 1966.
26. Select Comm. on Nutrition and Human Needs, U. S. Senate. *Nutrition and Human Needs.* Part III: The National Nutrition Survey. (Jan. 22, 23, 27 and 28, 1969), pp. 923-958.
27. Kerrey, E., S. Crispin, H. M. Fox and C. Kies Nutritional status of preschool children. I. Dietary and biochemical findings. *Am. J. Clin. Nutr.* 21: 1274, 1968.
28. Gutelius, M. F. The problem of iron deficiency anemia in preschool Negro children. *Am. J. Pub. Health* 59:290, 1969.
29. Robertson, E. C. The nutrition of children and adolescents. In: Beaton, G. H. and E. W. McHenry (Eds.) *Nutrition. A Comprehensive Treatise.* Vol. III. New York: Academic Press, 1966, p. 72.
30. Proceedings of the Food and Nutrition Board, National Academy of Sciences, National Research Council. 29:23, 1969.
31. Haughton, J. G. Nutritional anemia of infancy and childhood. *Am. J. Pub. Health,* 53:1121, 1963.
32. Hutcheson, R. H. Iron deficiency anemia in Tennessee among rural poor children. *Pub. Health Reports* 83:939, 1968.

The articles on this page are abstracts of papers presented at recent meetings of the Detroit Surgical Association.

A New and Reliable Method

Closing Median Sternotomy Incisions

BY R. E. TABER, M.D.
R. C. COATS, M.D.
DETROIT

The median sternotomy is finding increasing use in a variety of mediastinal and cardiac operations. A survey of median sternotomy closures between 1957-1965 at Henry Ford Hospital revealed a 11.4% dehiscence rate with a 28% mortality in this group.

The use of tracheostomy with its necessary suctioning and accompanying violent coughing, along with excessive assisted ventilation are factors believed to be significant in precipitating disruption. Narrow cortical bone in "off center" incisions allows little purchase and is also a factor in disruption.

A method of closure has been devised that will take advantage of the costal cartilage outside the operating area. The needle is blunt with swedged on #22-25 stainless steel monofilament wire.

It is first passed around opposing costal cartilages and passed in a "figure of 8" to form a noose around each costosternal junction. The cartilage is encircled close to the sternum and care taken to avoid the internal mammary vessels which are safeguarded by the blunt tip of the specially made needles.

By elevating the sternum with a retractor, the pleura can be visualized and protected when placing these sutures. The uppermost suture is placed in the manubrium as a simple through and through by using a cutting needle that will allow the bone to be pierced on either side. The sternal edges are then brought into apposition by using two large towel clips as approximators and twisting the wire at the side close to an intercostal space to allow the twist to be tucked into that space.

Four to five "figure of 8" sutures are used and the overlying subcutaneous and skin layers are closed with interrupted silk. The pericostal suture method is also adaptable to transverse sternotomy wound closure. This has provided a safe reliable closure of the median sternotomy in over 175 cases without evidence of dehiscence.

The authors are both with Henry Ford Hospital.

In the Treatment of Arteriosclerosis

Aorto-Coronary Saphenous Bypass And Vineberg-Sewell Implant

By Walter H. Janke, M.D.
Ali Esfahani, M.D.
Yung-Shik Lee, M.D.
All of Flint

The classification of coronary arteriosclerosis used in Flint, and the prognostic implications of it, have been presented. Patients are selected for cine-coronary angiograms on the basis of having angina or being young patients with a history of myocardial infarction. In patients with triple vessel disease, differentiation has been made between an incomplete occlusion versus complete occlusion of one, two, or three vessels. Ninety patients have been operated on with an overall mortality of 6.6 per cent. As of June of 1970, 29 saphenous aorto coronary bypasses had been performed on 21 patients. There has been only one mortality in this group. Six of the last ten patients had a double aorto coronary bypass. Emphasis is placed on the need of bypassing all involved vessels since otherwise the long term results cannot be expected to be as satisfactory. We have been very favorably impressed with the post operative recovery, rapid symptomatic improvement, and a lack of significant electrocardiographic changes in the greater majority of patients in whom the direct type of coronary artery surgery was performed.

Saphenous aorto coronary bypass represents a major breakthrough in the treatment of arteriosclerosis. If properly performed it provides a safe method with minimal morbidity and mortality by which coronary circulation can be immediately re-established. In patients with incomplete obstruction it provides new avenues that will not only improve myocardial circulation as soon as the bypass is completed but will also prove invaluable when the obstructed process becomes complete.

Some Personal Thoughts Concerning The Detroit Medical Center*

By A. Martin Lerner, M.D.
Detroit

I shall take the opportunity of your editor's invitation to share with you thoughts concerning medicine in Detroit. I have been a resident of Detroit, of this community, and a member of the faculty of medicine at Wayne State University for seven years, longer than any of my stays during formative years in St. Louis, Washington, D. C., or Boston.

WHILE ALL EXPERIENCE is important, for me the Harvard Medical Unit and Thorndike Memorial Laboratory at the Boston City Hospital were dominant. There, as a resident physician and subsequently as research fellow, I learned of medicine and infections. I became and remain convinced that the best care of the patient can never be far removed from active research. I learned that research is the asking of a meaningful question, and an intense and critical searching for its answer. I learned and know that, to a physician, this is great fun.

The interweaving of care of the patient and study of that patient by a physician-scientist has been gloriously developed at university hospitals in this country, and this was and is the way of life at the Boston City Hospital.

The use of the scientific method in research leads to a disciplined mind which, when applied at the bedside, serves the patient well. Rigorous criticism of oneself is demanded by good research. Sometimes new insight and a new solution may result.

At the Thorndike Laboratory many young men fashioned themselves toward the horizons of their chiefs of service, William Castle and Maxwell Finland. Bill Castle is a humanist and patrician who drove a twenty-five year old model T Ford. He was wont to repair it himself. Rumor had it that he had repaired the rickety elevator of the laboratory as well.

Max Finland was and is an enthusiastic, kind and brilliant physician. He taught that a talented investigator doubted his ability. He taught that there is an almost inverse relationship between continuing professional development and economic reward. These men demonstrated that great leaders might develop at a fiscally neglected city hospital.

The Boston City Hospital, like Detroit General (Receiving) Hospital, was inadequately financed and had too few nurses and supporting personnel. House officers, with support from full and part-time faculty, maintained the care and secured the reputation of the hospital. Doctors gave medicines, weighed patients, measured urinary volumes, performed pertinent laboratory tests, and carefully recorded results in scrupulously organized charts. An unwritten, but rarely incorrect, law was that if anything could go awry, it did. The electrocardiographic machine delivered a negative which had to be developed by the doctors. They rolled these ancient machines by basement tunnel to a dark room three city blocks away. If fixative and developer were not reversed, a record would be produced. The young doctors ran the hospital very well, and loved it. They were part of, and were building a tradition.

I SHALL NEVER FORGET a particular elderly diabetic Italian man in congestive heart failure who visited the outpatient clinic one day. After I had prescribed digitalis and a diuretic, he returned a week later much relieved. He offered a strong cigar with the words, "God bless you, doc; you make me 'pee.'" Neither shall I forget my dear friend, Dr. David Hurwitz, director of that clinic, when he interrupted and ended my presentation of another patient whom I had seen because I had not obtained a specimen of blood for determination of its glucose concentration which was needed for the study of the patient.

---

* Published in the Sinai Hospital *Bulletin*.

Doctor Lerner is professor of medicine, Wayne State University School of Medicine, and director of the Division of Infectious Diseases in the Department of Medicine. He was aided in his study by a PHS Training Grant from the National Institute of Allergy and Infectious Diseases.

OUR CHALLENGE

What relevance do these personal memories have today to us at Wayne State University School of Medicine, to the Detroit Medical Center and to the community? I think they may be pertinent.

The will of men to reach a lofty objective cannot be measured. Yet, we must confess that there are very real obstacles toward the achievement of a great medical school and center. The inner city of Detroit where we work is a place which many avoid whenever possible. It is beset with racial strife and accompanying problems of crime and fear. The single hospital over which professors presently maintain control of quality is Detroit General (Receiving) and, like its counterpart in Boston, is at once magnificent in its service to the sick and an undersupported, awkwardly functioning indignity.

OUR PROPOSED MEDICAL CENTER includes at its fulcrum the new Webber Hospital. The Webber is meant to serve all who need its "special" services. It is meant to be heedless of economic barriers.

It may be argued that no truly referral center can be developed within the inner city of Detroit. There are increasingly sophisticated community hospitals in an untroubled periphery.

Others argue cogently that the medical school does not have its university hospital, and that it is committed to too large a class of medical students to achieve that excellence in medicine including 1) the creation of an environment where students of medicine at every level mature, 2) the development of a place for care of the sickest, most complex patient, and 3) the regular innovation of the science of medicine, both that which may be immediately applicable, and that which is more indirectly related to the patient. I may add that in my view if medical research is well-conceived and executed, the research need not have a relation to the patient which is immediately apparent.

People of Detroit and its metropolitan city require the full range of excellence in all of the realms of medical care that are available. This need is apparent. A fine university medical center is also required to support and stimulate the burgeoning community and its hospitals. The continued success of the community hospitals of our area is dependent upon Wayne State University School of Medicine for continuing numbers of house staff, teachers and practitioners. The interdependence, mutual benefit and continued development of our community hospitals can only increase as the university-supported Detroit Medical Center becomes a reality.

DOCTORS AND THEIR HOSPITALS of the medical corridor and the periphery are not adversaries, but are colleagues. The medical center must be a place for the finest of care but its distinguishing quality must be a devotion to scholarship. Of our institutions, only the university is, as a prime goal, devoted to learning. Only in association with Wayne State University can a great medical center be built in Detroit. Moreover, the achievement of such a center for the care of the sick can re-identify the city and its citizens.

THE CLINICAL FACULTY (FULL-TIME AND VOLUNTARY)

The division of doctors into a gown and a town is artificial. The role of physicians cannot be separated. It is true that the professor must be primarily devoted to scholarship and research. He must have time to do the careful work, thinking and re-thinking an "insoluble problem." The professor must be a doctor able to care for the sick, but he must, himself, have additional training in one of the disciplines of the laboratory — biochemical, immunological, physiological or microbiologic. The professor must be, as needed, a collaborator to his preclinical colleagues at the medical school or at the greater university. He may fruitfully collaborate with his colleagues in practice. Professor and medical center should be a resource for standards and new means of care. In the medical corridor of the Detroit Medical Center the professor must control the quality of service. This can be accomplished with safeguards to all rights and privileges to clinical faculty.

The center will of necessity be of national import. The environment of the medical center should enrich and stimulate all of us.

Transfer Of Nursing Home Patients

By John B. Sherman, M.D., M.P.H.
Lansing

Primitive man lived in a world of fear, much of it being fear of the unknown. The cave in which he dwelt became a haven of refuge where he could feel at least relatively safe and secure. It became his castle in the full meaning of the word.

Man has always lived in a world of continuing change. To this change he must learn to adapt with greater or lesser degrees of discomfort. As age increases, this ability to adapt diminishes. Man eventually resents change, he comes to fear it because it implies facing the unknown. His castle becomes an ever more important bulwark against this fear of change, it offers him stability, security and safety, and it is something he knows with great familiarity, therefore he clings tenaciously to it. All this is regardless of how humble the home may be. Many an old shack is home to someone with all that the word implies.

SUDDENLY ONE DAY he is uprooted from these familiar surroundings and really dumped (and the word is used deliberately) into some kind of nursing home or other facility. The change is dramatic and sudden. The surroundings, the faces, and the routine are quite foreign to him and we wonder why he is emotionally upset!

We hear much about the problem that the patient creates for the nursing home but what about the problem the home creates for the patient? "Some three-fifths of the patients in nursing homes are mentally confused most or all of the time."[1] "A not inconsiderable share of the mental health problems of nursing home residents arises out of their being there."[2]

The new categorization of nursing homes into those providing skilled nursing care (Title XIX) and those providing only basic or intermediate care (Title XI) is being strongly objected to by nursing home operators. One of the most frequently voiced objections is based upon the emotional trauma that will be entailed by moving patients from one facility to another as their needs change. This seemingly valid objection bears closer examination.

Every patient in a nursing home has come from somewhere else and probably most have suffered some degree of emotional stress. In the vast majority of cases little or nothing has been done to prevent this stress. It has just been accepted as inevitable. A percentage of nursing home patients must, of necessity, be transferred to a hospital situation. This causes some stress to persons of all ages. No attempt is made, however, to deny the patient necessary hospital care simply because his transfer there upsets him emotionally. For a variety of valid reasons some patients are transferred from one home to another. In other words, transfer of nursing home patients is not new, it goes on all the time, and is very rarely denied on the grounds of any emotional stress which it may cause. There has hitherto been little evidence of any great general concern about it. Notable exceptions will be discussed later.

DURING THE PAST FIVE YEARS a joint project between the local departments of Social Services and Health in Oakland County, Michigan has operated a system of categorization of facilities and patients. There are five categories of care intensity and an annual case load of about 1,100 patients. Great care is taken to insure that each patient receives the intensity of care which he needs, no more and certainly no less. Transfers, including those to acute hospitals have averaged just over 3% per annum. The evidence suggests that once a patient enters a home that supplies the intensity of care which he needs, he will in the vast majority of cases remain there until discharge or death. Transfers are much less common (even with five categories, let alone two) than many people would have us believe.

In spite of the fact that the number of transfers is relatively small, to the people actually involved, it is extremely important. The emotional upset so caused can and should be modified and limited. This applies equally to the trauma of initial entry into the home. Some transfers are urgently necessary (as to a hospital) but in the

---

The author is with the Bureau of Medical Care Administration of the Michigan Department of Public Health.

vast majority of cases they are arranged in more leisurely fashion. Thus, there is time for preparation of the patient and very often, also, of the family. Some of the best nursing homes take this pre-entry and pre-transfer preparation quite seriously. It benefits not only the patient but quite considerably also, the facility.

The social worker visits the patient and the family. The patient may visit the home, even on more than one occasion. He partakes of a meal, meets some of the less ill patients, and even participates in some of the diversional and recreational activities. He meets the administrator and some of the nursing staff. Literature describing the home and the routine is available. The patient learns what he may expect and what will be expected of him. All this offers the patient time to adapt gradually to what are otherwise frightening conditions. It is important to take care that at least some of the patient's personal and familiar belongings accompany him when a transfer occurs.

WHEN THE PATIENT actually arrives into his new environment a period of properly organized orientation is very important. This should involve the staff and other patients. Cohn in a recent article[3] describes in detail many of the techniques which can be used.

A recent survey[4] showed that 41% of patients in nonhospital nursing facilities were receiving either more or less care than they medically required. It is inhumane to provide any patient with less care than he needs, and uneconomical to provide him with more. Many patients today are not receiving the skilled nursing care which they need because they are in nursing homes not geared to supply such an intensity of nursing care. To deny them such care on the grounds that transfer to the proper home will cause emotional upset is not a logical argument.

It should be noted that when and where categorization of homes and patients first becomes a legal requirement, there will be movement of patients. If this movement involves relatively small numbers of patients, there can be little objection on the grounds of the emotional stress involved. If, however, the number of patients involved in this movement is large, and as mentioned before it could even involve some 40% of them, then this in itself emphasizes the great need for change and this must be done even though some emotional trauma may result, to make sure that patients do receive only the intensity of care they need.

AFTER THE INITIAL TRANSFER, however, the majority of patients will be receiving the care they need. Subsequent admissions will be directly to the correct place and transfers will be reduced to a minimum. Hopefully any potential trauma involved in this small number of transfers will be considerably modified by the employment of readily available techniques.

REFERENCES

1. National Center for Health Statistics — Series 12 #2
2. Blenknew — *Journal Geriatric Psychology* — Spring 1968
3. Gerald N. Cohn, "Social Work — A Key Department in the Successful Home" — *Professional Nursing Home* — September 1968, page 26
4. *A.M.A. News* — October 14, 1968 — Comments on Study in Monroe County, New York (John G. Hill, Director)

Cervical Lymph Node Biopsy

By J. G. Lee, M.D.
owa City, Iowa
Christian Helmus, M.D.
Grand Rapids

ntroduction

More than one-third of the lymph nodes of the body are concentrated in the compact anatomy of he neck. The lymphatic drainage from the head nd neck ultimately flows into the internal jugular hain of deep cervical lymph nodes. Named lymph nodes in the deep cervical chain are the jugulo-digastric and jugulo-omohyoid lymph nodes which re of great clinical importance in metastasis of pithelial cell carcinomas of the head and neck.

Lymph nodes which may be invaded prior to metastatic spread into the jugular chain include he submaxillary, submental, pretracheal, and acessory nerve groups of lymph nodes. Metastasis o the supraclavicular lymph nodes without involvement of the deep cervical chain is suggestive of a primary site inferior to the clavicles.

Data

This is a retrospective review of 163 cervical ymph node biopsies submitted for pathological exmination at Butterworth Hospital, Grand Rapids, Michigan, from July 1, 1964, through December 31, 1968. All patients presented with at least one palpable cervical lymph node. Clinically unpalpable prescalene lymph nodes excised in evaluation of patients with bronchogenic carcinoma and radial neck dissection specimens were not included. On the basis of microscopic diagnosis, the specimens were classified in one of six categories (Table). Metastatic carcinoma was reported in 48 cases (29.4%). If consideration is limited to those biopsies in patients 40 years of age or older, 41 of 89 (46%) biopsy specimens contained metastatic carcinoma.

Fifteen different primary carcinomas are represented (**Table 2**). The primary site was known prior to cervical lymph node biopsy in 39 (81.2%) cases. Of the nine instances in which biopsy was done without knowledge of the primary tumor, the primary was never identified in three (6.2%) cases. In the remaining six (12.5%) cases, involving five patients, a primary carcinoma of the pharynx or larynx was later identified. Case reports from these instances follow. A needle biopsy of a cervical lymph node in a patient with a laryngeal lesion prior to initiation of palliative irradiation therapy accounts for the seventh case of squamous cell carcinoma of the mucous membranes of the head and neck.

Case Reports

The first patient was a 73 year old man noted to have a 3 x 4 centimeter mass in the left posterior cervical triangle upon admission for elective cataract extraction. He had been aware of this mass for six months and gave a history of heavy smoking and drinking. Without further evaluation, this node was excised. The histopathological report was "poorly differentiated metastatic carcinoma," and the patient was discharged with a final diagnosis of "adenocarcinoma, metastatic, primary unknown." Eight months later he was readmitted with a right neck mass and ear pain. Numerous studies were nondiagnostic until finally otolaryngological consultation was obtained. Pooling in the right pyriform sinus was noted on mirror examination, and upon direct laryngoscopy a lesion was identified. Biopsy report was Grade IV squamous cell carcinoma. A course of radiotherapy (Co^{60}) was given, but the patient expired three months later.

The second patient, a 44 year old woman known to be a heavy smoker and occasional drinker, complained of difficulty swallowing and nasal obstruction. She developed bilateral cervical node enlargement during a 13 month period of conservative treatment. A right cervical lymph node biopsy

---

This paper received the award for best clinical study presented at the Second Annual Western Michigan Research Club sponsored by the Kent County Medical Society May 13, 1969. Doctor Lee was then with the Department of Surgery, Butterworth Hospital, Grand Rapids, where Doctor Helmus continues to serve. Doctor Lee is now a resident in the Department of Otolaryngology and Maxillofacial Surgery at the University of owa Hospitals, Iowa City.

Table 1

Cervical Lymph Node Biopsy — 163 Cases

Microscopic Diagnosis	Number of Cases Total	Number of Cases 40 & Over	Age Range (Years)	Average Age (Years)	Mean Age (Years)	Male:	Female
Normal Lymph Node	11(6.7%)	6(6.7%)	13-73	44	41	5	6
Hyperplastic Lymph Node	29(17.8%)	9(10.1%)	2-70	31	26	12	17
Inflammatory Reaction	40(24.5%)	14(15.7%)	3-70	32	34	12	28
Hodgkins Disease	18(11.0%)	6(6.7%)	6-74	38	34	10	8
Other Lymphomas	17(10.4%)	13(14.6%)	4-77	54	63	10	7
Metastatic Carcinoma	48(29.4%)	41(46.0%)	19-80	56	58	26	22
	163(99.89%)	89(99.8%)					

was done and reported as "very well differentiated squamous cell carcinoma." The same report was obtained one week later after another biopsy of a node from the left side. Otolaryngological consultation was sought and indirect nasopharyngoscopy revealed a large mass which was a Grade II squamous cell carcinoma. Initial radiotherapy was followed by palliative surgery. The patient expired nine months later.

The third case was a 62 year old man who complained of difficulty swallowing and a three month history of a right paratracheal neck mass. The node was biopsied and microscopically was reported as a "high grade carcinoma." The lesion was felt to be an unresectable thyroid carcinoma and a course of radiotherapy was given. Six months later, otolaryngological consultation was obtained because of progression of dysphagia, earache, and hoarseness. A large supraglottic laryngeal mass with a fixed vocal cord was seen and biopsied. The patient then had a laryngectomy and right radical neck dissection for laryngeal carcinoma and paratracheal metastasis. Currently, two years post laryngectomy, he has a superior mediastinal recurrence which is being treated with radiotherapy.

The fourth patient was a 63 year old man admitted for biopsy of a left neck mass of six weeks duration. Node biopsy report was Grade III squamous cell carcinoma. Otolaryngological consultation was immediately obtained. A bulky mass on the left aryepiglottic fold was visualized and biopsy revealed Grade III squamous cell carcinoma. This patient received preoperative irradiation of 3000 Roentgens followed by a laryngetomy and left radical neck dissection, widely excising the skin around the biopsy site. To date the patient is doing well, 25 months post resection.

The last case was a 67 year old lady who complained of difficulty swallowing. Cine-esophagram revealed a questionable defect in the right pyriform sinus. A cervical node biopsy was done 3 months later and was reported as "high grade squamous cell carcinoma." Otolaryngological consultation was obtained disclosing a large carcinoma of the right posterior pharyngeal wall. The lesion was resected taking a wide skin margin around the biopsy site. Because of inadequate laryngeal function laryngectomy was required at a later date, and local recurrences were treated with radiotherapy. She expired 14 months after initial resection.

Table 2

Primary Sites of Carcinomas with Cervical Lymph Node Metastases — 48 Cases

Lung	15
Pharynx and Larynx (squamous cell carcinoma)	7
Breast	4
Thyroid	4
Unknown	3
Cervix	2
Ovary	2
Malignant Melanoma (lip, neck)	2
Lymphoepithelioma (parotid)	2
Squamous cell carcinoma lip	1
Trachea	1
Pancreas	1
Esophagus	1
Mucoepidermoid (buccal mucosa)	1
Colon	1
Prostate	1

Comment

Biopsy of a palpable cervical lymph node is a seemingly innocuous procedure to determine the underlying etiology. However, when the lymph node is involved by regionally metastatic carcinoma from the head or neck, biopsy violates the en bloc technique of excision and contaminates surrounding healthy tissues. To avoid this, patients presenting with a palpable cervical lymph node should have a thorough examination of the head and neck before contemplating biopsy of the neck node. Delay in making the correct diagnosis may also be costly to the patient's prognosis.

In this series 3.7% of cervical lymph node biopsies were done in patients who had an identifiable tumor of the larynx or pharynx, had a thorough examination of the head and neck been done. When considering those patients 40 years of age and older 6.7% of cervical lymph node biopsies revealing metastatic epidermoid carcinoma were done prior to adequate examination of the pharynx and larynx A search of the literature has failed to identify a report of a similar series.

Summary

A series of 163 cervical lymph node biopsies performed in a community hospital revealed that in six (3.7%) cases the procedure was contraindicated

and possibly was detrimental to the patient's prognosis. In these instances the patients had a carcinoma of the pharynx or larynx not diagnosed prior to cervical lymph node biopsy because it was not searched for. It is advocated that adult patients presenting with palpable cervical lymph node (s) be considered to have a carcinoma of the head and neck until the diagnosis is excluded.

The Viewbox

By Raymond S. Kurtzman, M.D.
Associate Scientific Author

Diagnosis

PULMONARY EMBOLISM (lung scan and pulmonary angiogram).

X-Ray Findings

The lung scan shows a marked difference in activity in the right upper lobe as seen on the lung scan, **(Figure A)**. The pulmonary angiogram shows emboli within the right superior artery, **(Figure B)**.

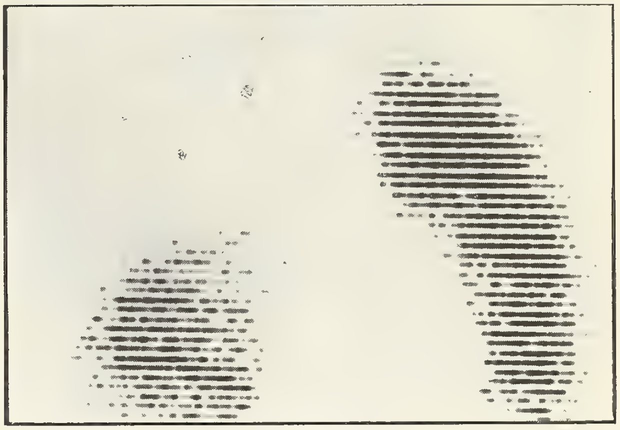


Fig. A

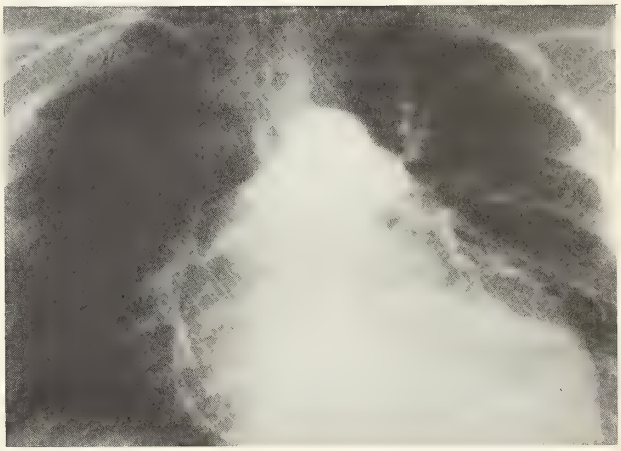


Fig. B

Discussion

Pulmonary embolism is an extremely common disease, probably the commonest pulmonary cause of hospital admission. The lung scan and pulmonary angiogram are relatively recent diagnostic aids. The lung scan is performed by the intravenous injection of a macroaggregate which is labelled with radioactive iodine. The aggregates lodge in the pulmonary arterioles, and a scintiscan of the chest will record the radioactivity. The presence of radioactivity depends on the macroaggregate reaching the pulmonary arterioles. If there is a thrombus or embolus in a proximal pulmonary artery, the radioactive material cannot reach the smaller peripheral arteries, and thus, an area of "underperfusion" is identified. When there is disease of the lung other than pulmonary embolism, such as pneumonia or tumor, natural shunting mechanisms in the pulmonary circulation divert blood and also the macroaggregate from the diseased area, also producing an area of "underperfusion." The lung scan, therefore, is not specific for pulmonary embolism. It is most valuable when the ordinary chest X-ray does not show disease in the lung. The pulmonary angiogram is shown as confirmation of the diagnosis in this patient.

Bibliography

Taplin, G. V., Dore, E. K., Johnson, D. E. and Kaplan, H. S.: Suspension of radioalbumin aggregates for photoscanning of the liver, spleen, lung and other organs. *J. Nucl. Med.* 5: 259, 1964.

Wagner, H. N., Jr., Sabiston, D. C., Jr., Stern, H. S.: Diagnosis of massive pulmonary embolism in man by radioisotope scanning. *New England J. Med.* 271: 371, 1964.

INFORMATION FOR CONTRIBUTORS

1. Address scientific manuscripts to the Publication Committee, Michigan State Medical Society, 120 West Saginaw Street, East Lansing, Michigan 48823.

2. Submit original, double-spaced typewritten copy and two carbon copies or photo copies on letter size (8½ x 11 inch) paper.

3. On page one, include title, authors, degrees, academic titles, and any institutional or other credits.

4. Authors are responsible for all statements, methods, and conclusions. These may or may not be in harmony with the views of the Editorial Staff. It is hoped that authors may have as wide a latitude as space available and general policy will permit. The Publication Committee expressly reserves the right to alter or reject any manuscript, or any contribution, whether solicited or not.

5. Illustrations should be submitted in the form of glossy prints or original sketches from which reproductions will be made by **Michigan Medicine.**

6. Contributors will be notified as soon as practical if a manuscript is accepted for publication. Unused manuscripts will be returned. Every care will be taken with the submitted material but the Journal will not hold itself responsible for loss or damage to manuscripts.

7. Articles should ordinarily be less than four printed pages in length (3000 words).

8. References should conform to *Cumulative Index Medicus,* including, in order: Author, title, journal, volume number, page, and year. Book references should include editors, edition, publisher, and place of publication, as well.

9. Specify address to which galley proofs should be sent. Proofs will be mailed to authors for correction before publication and should be returned to the editor in 48 hours. If proofs approved by the author are not received by the editor prior to deadline, publication of the article will be cancelled for that issue.

10. The editors welcome, and will consider for publication, letters containing information of interest to Michigan physicians, or presenting constructive comment on current controversial issues. News items and notes are welcome.

11 It is understood that material is submitted for exclusive publication in **Michigan Medicine.**

MICHIGAN
DEPARTMENT
OF PUBLIC
HEALTH

Monthly Surveillance Report
Cases of Certain Diseases Reported To the Michigan Department of Public Health For the Four-Week Period Ending May 29, 1970

	1970 This 4-Week Period	1969 Same 4-Week Period	1970 Total To Above Date	1969 Total Same Date	Total Cases for 1969
Rubella	348	797	2019	2628	4307
Measles	335	33	890	141	401
Whooping Cough	3	4	41	54	192
Diphtheria	—	—	—	—	—
Mumps	732	619	3526	3103	5215
Scarlet Fever & Strep Sore Throat	854	789	6553	5298	9763
Tetanus	1	—	4	1	6
Poliomyelitis (paralytic)	—	—	—	—	—
Hepatitis	320	231	1902	1326	3360
Salmonellosis (other than S. typhi)	48	34	227	178	539
Typhoid Fever (S. typhi)	0	0	5	3	6
Shigellosis	11	23	84	131	300
Aseptic Meningitis	3	1	20	35	179
Encephalitis	9	8	33	40	120
Meningococcic Meningitis	6	19	32	71	114
H. Influenza Meningitis	1	10	27	24	56
Tuberculosis	175	184	920	999	2108
Syphilis	327	305	1642	1912	4021
Gonorrhea	1399	1331	8269	7222	19194

Information can be supplied by the local health department on the local incidence of disease.

Maurice Reizen, M.D., Director
Michigan Department of Public Health

Candida Parapsilosis Septicemia

By Donald L. Bruns, M.D.
Ellsworth R. Littler, M.D.
Jose E. Yanez, M.D.
All of Eloise

The genus Candida includes many species which until recently have not been considered pathogenic. Among these are *C. parapsilosis, C. pseudotropicalis, C. stellatoidea, C. guilliermondii,* and *C. krusei.* It is now apparent that these organisms may occasionally cause clinical infection both in man and experimental animals (1,2). Systemic infection in man, with the exception of endocarditis, is still quite rare, however. The following report is that of a patient who developed fungemia due to *C. parapsilosis.*

Case Report

Patient H.G., a 71-year-old retired male was transferred to Wayne County General Hospital from the Psychiatric Division of that Hospital with a history of fever of unknown origin for two to three weeks. Relatives gave a history of gradually increasing confusion, disorientation, and combative behavior. No past history of other significant disease was obtained. While in the Psychiatric Division, he was treated with tetracycline, one gram daily.

Upon admission, the physical examination revealed a disoriented, agitated, elderly white male with an oral temperature of 101° F. The chest was symmetrical with absent breath sounds and dullness posteriorly over the base of the right lung. Abdominal examination revealed tympany over the right upper quadrant. No decubitus ulcers were present. Neurological examination was unremarkable with the exception of senile dementia and a positive Chvostek's sign. Gross hematuria was noted on admission to the hospital.

LABORATORY DATA REVEALED: hematocrit, 45%; hemoglobin, 14.5 g/100 ml; white blood cell count 11,050/cu mm, with differential count, 91% polymorphonuclear leukocytes, 6% lymphocytes, and 3% monocytes; blood film revealed numerous platelets and moderate anisocytosis of red blood cells. Catheterized urine specimen: specific gravity, 1.025; albumin, 100 mg/100 ml; no glucose; innumerable red blood cells; and many red blood cell casts. BUN, 30 mg/100 ml; creatinine, 1.1 mg/100 ml; glucose, 100 mg/100 ml; serum electrolytes, normal; serum calcium, 6.9 mg/100 ml; phosphorus, 1.1 mg/100 ml; alkaline phosphatase, 10 IU; and acid phosphatase, 0.40 Sigma units. Serum proteins (by cellulose acetate electrophoresis): albumin, 2.44 g/100 ml; alpha-l globulins, 0.89 g/100 ml; beta globulins, 0.69 g/100 ml; and gamma globulins, 0.73 g/100 ml. Cerebrospinal fluid examination was normal. Febrile agglutinins revealed no significant titers.

Sputum and urine cultures were negative for pathogens or acid-fast bacilli. Sternal bone marrow aspirate contained normocellular hematopoietic tissue. Chest roentgenograms revealed marked elevation of the right hemi-diaphragm with atelectasis in the right middle lobe. Prominent intestinal gas was noted below the right diaphragm and anterior to the liver. Upper gastrointestinal series and barium enema revealed a polypoid filling defect in the cecum. Superior mesenteric and celiac angiographic findings were normal. Roentgenograms of skull and hands were normal. Brain and liver scans were also normal. Eight blood cultures were taken during hospitalization, and four were positive for yeast *(C. parapsilosis).* Bone marrow cultures contained *C. parapsilosis.*

Hospital Course: Because of persistent fever and the patient's critical condition, 30 million units of aqueous penicillin were given intravenously per day. This was continued for 11 days without response. On the 17th hospital day, the patient developed upper gastrointestinal hemorrhage. Three units of whole blood were transfused. Sodium cephalothin 12 Gm/24 hr I.V. and kanamycin sulfate 1.5 Gm/24 hr I.M. were given. His condition improved slightly, and the bleeding stopped with no further measures. The serum calcium returned

---

Doctor Bruns is a captain with the U.S. Army Medical Corps stationed in Vietnam. Doctor Littler is an assistant professor of pathology, University of Michigan and assistant director of pathology at Wayne County General Hospital. Doctor Yanez is instructor in medicine at The U-M and is director of the Outpatient Department, Wayne County General Hospital.

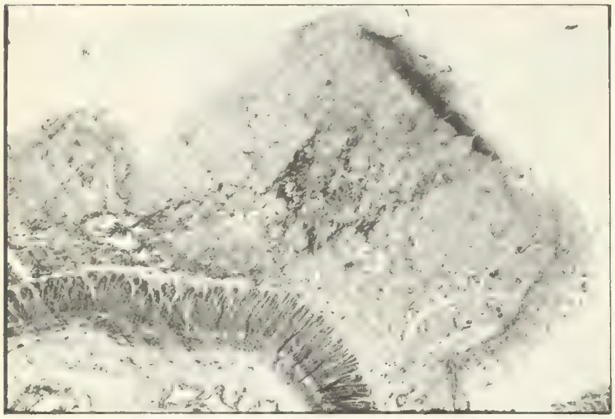


Fig. 1 — Acute ulcer of duodenum with necrosis of mucosa and adjacent submucosa. This type of lesion is a characteristic portal of entry for candidal organisms, but fungi were not present in special stains of this ulcer.

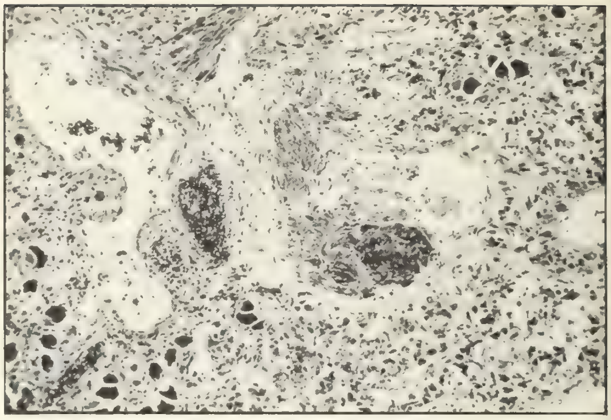


Fig. 2 — Organizing microthrombi in small veins of adrenal gland, as might be seen in disseminated candidiasis. Similar lesions were present in kidney and lung. Fungal stains of these lesions were negative.

to normal spontaneously with resolution of Chvostek's sign. However, fever continued with elevations to 103° F. rectally.

Blood cultures taken on the 9th, 28th, 37th, and 38th hospital days were subsequently reported as growing *C. parapsilosis.* Yeast also appeared in the urine on the 46th hospital day. As previously stated, bone marrow culture was also positive for yeast. On the 51st hospital day amphotericin B, 10 mg per day, was given intravenously with gradual increase in dosage to 50 mg every other day. Complications of therapy which occurred included anemia, fever and hypokalemia. Renal function remained adequate. Febrile reactions to amphotericin B were controlled by prior intravenous administration of 50 mg of hydrocortisone sodium succinate. On the 10th day of amphotericin B therapy, the patient became afebrile and exhibited some improvement in responsiveness. He died suddently on the 70th hospital day.

Necropsy Findings: At necropsy the body was that of a well developed, well nourished white male with large decubital ulcers. The brain was normal in weight. There was hemosiderin staining of leptomeninges of left temporal lobe and excessive dilatation of left lateral ventricle with associated softening and necrosis of left temporal cerebral cortex.

The heart contained no valvular or myocardial lesions, and heart blood culture contained no fungi. Coronary arteries and aorta had minimal focal atherosclerosis. There was pulmonary atelectasis of the lower lobes. Large recent thrombo-emboli were present in branches of the pulmonary artery to right upper lobe, and smaller emboli were seen in left pulmonary arterial branches. Right and left pleural cavities contained approximately 800 ml and 1000 ml of serous fluid respectively.

IN VENOUS SYSTEM, an occulsive thrombus was noted in the right jugular vein beneath a venipuncture site where amphotericin B had been given. There was a non-occlusive mural thrombus in the superior vena cava at its junction with the azygous vein.

There were superficial erosions at the lower end of esophagus. The second portion of the duodenum showed several black superficial ulcers **(Fig. 1)** with irregular margins. Arising from the mucosa of cecum was a polypoid adenocarcinoma 2.5 cm. in diameter, with neither associated invasion of the cecal wall, nor metastases. The spleen, liver, and kidneys were of normal weights and showed no significant lesions, except moderate renal arteriolar nephrosclerosis. The prostate gland was nodular. Accessible pelvic and leg veins showed no thrombi.

Histologic sections of tissues in general confirmed the gross findings. No tissue contained stainable fungi. Adrenal gland, kidney and one section of lung each contained a resolving microthrombus **(Fig. 2)** in small veins compatible with healing vascular lesions of systemic candidiasis; these lesions were negative with special fungus stains (P.A.S.). The ulcerative esophageal and duodenal lesions were also negative for fungi. A small "latent" carcinoma was found in prostate. There were no toxic changes in kidneys.

Mycologic Findings

The organism originally recovered from blood and bone marrow yielded a characteristic yeast-like colony on Sabouraud's media. Microscopically it was a gram positive budding yeast with well developed mycelium. On corn meal agar blastospores were present but no chlamydospores. Carbohydrate fermentation reactions showed acid and gas from dextrose but no reaction with maltose, sucrose, or lactose. Sugar assimilation testing, by a modification of a standard method (3) showed assimilation of dextrose, galactose, maltose, and sucrose, but no utilization of lactose, raffinose or cellobiose. These reactions identified the isolate as *Candida parapsilosis.* This identification was confirmed by the mycologic section of the Communicable Disease Center at Atlanta, Georgia.

Discussion

Candida species other than *Candida albicans* are emerging as pathogens of significance in man (4,5). Prior to this report, four cases of systemic candidemia were attributed to *C. parapsilosis* (5,6), and two each to *C. pseudotropicalis* and *C. guilliermondii* (5). This is the fifth reported case of generalized fungemia with *C. parapsilosis.* In all of the above cases, the organism involved was an opportunistic pathogen in patients with serious underlying disease.

ALTHOUGH THIS PATIENT was debilitated, he had none of the other predisposing factors generally reported in previous cases of candidemia. Lupin *et al* described three cases of candidemia involving *C. parapsilosis* in which the underlying diseases were subdural empyema, bacterial endocarditis, and pyelonephritis respectively (6). All patients had been treated with antibiotics. Louria *et al* described one such case, also previously treated with antibiotics, in which there was pre-existing metastatic carcinoma (4).

We believe this man presented with candidemia originally since there was no other apparent underlying disease. Unfortunately he was treated with tetracycline and penicillin for one week before blood cultures were taken. It is well documented that the incidence of oral and rectal candidiasis is increased after administration of penicillin and tetracycline (7). Therefore, this cannot be eliminated as a predisposing factor. Most important however, is that in all previously reported cases involving *C. parapsilosis,* severe, clinically evident disease was present with candidiasis presenting as a complication. In this patient, it is seen as a probable primary disease.

An interesting aspect of this case was the hypocalcemia and concommitant positive Chvostek's sign with which this patient presented. Hypocalcemia has been previously reported in cases of candidemia occurring with pancreatitis in adults (8). It is also well known that the incidence of fungemia is increased in children with hypoparathyroidism. However, in adults this association remains as an observation without adequate explanation. The hypocalcemia in this case resolved spontaneously and its etiology was never elucidated.

TREATMENT OF THIS PATIENT was initiated only after clinical deterioration suggested a probable fatal outcome. Amphotericin B was instituted in small doses initially, giving 10 mg in 1000 cc IV fluids over eight hours and increasing the dosage by 10 mg per day until a dose of 50 mg per day was reached. Therapy was then changed to doses every other day. During initial treatment, fever and headaches were noted. This was well controlled with 50 mg hydrocortisone I.V. given just prior to the amphotericin B as has been previously suggested by Utz (9). Other general side effects of amphotericin B therapy which were noted in this patient were anemia and hypokalemia.

The anemia which developed was normochromic, normocytic, and resulted in a decrease in hematocrit from 30% to 26% over a period of 10 days. Brandriss *et al* in their study of 30 patients treated with amphotericin B, found the anemia to be secondary to a combination of direct suppression of bone marrow and hemolysis of red blood cells associated with the infection (10). It was generally well tolerated and did not require treatment.

Hypokalemia, a well documented complication of amphotericin B, was also observed in this patient. Serum potassium decreased from 3.5 meq/ liter to 2.9 meq/liter over a one week period. Hill noted development of localized tubular necrosis in patients treated with large doses of amphotericin B similar to lesions caused by hypokalemia (11,12). No such lesions were seen in this patient. The disturbance in potassium metabolism apparently follows closely the decrease in renal function as measured by creatinine clearance and BUN (11, 13, 14).

In the four previously reported cases involving systemic infection, none survived and only one was treated with amphotericin B (4,5). Lupin (5) reported one case of bacterial endocarditis with fungal infection of endocardium and pericardium which was cured with amphotericin B. Our patient received a total of 400 mg amphotericin B. At the time of necropsy, no existing fungal infection could be demonstrated. It was noted that organizing microthrombi in small veins were present in kidney, lung, and adrenal gland as might be seen in candidiasis. This apparently represents successful treatment with amphotericin B of systemic *C. parapsilosis* infection.

Synopsis - Abstract

Primary candida parapsilosis septicemia was diagnosed in a 71-year-old debilitated white male without other predisposing clinical disease. Infection was documented by recovery of fungus in blood and bone marrow culture.

Treatment with amphotericin B was carried out. Complications incurred during therapy included

anemia, fever, thrombophlebitis at the site of drug administration, hypokalemia, and deterioration of renal function. Death due to incidental massive pulmonary embolism occurred. Absence of organisms in tissue or blood at the time of necropsy indicates probable cure of the systemic infection with *C. parapsilosis*.

References

1. Richart, R., and Dammen, G. J.: *Candida tropicalis* as a pathogen for man. *New Eng. J. Med.* 263:474-477 (Sept. 8) 1960.
2. Goldstein, E., Grieco, M. H., Finkel, G., and Louria, D. B.: Studies on the pathogenesis of experimental *Candida parapsilosis* and *Candida guilliermondii* infections in mice. *J. Infect. Dis.* 115:293-302, (June) 1965.
3. Ajello, L., Georg, L. K., Kaplan, W., and Kaufman, L.: *CDC Laboratory Manual for Medical Mycology.* Public Health Service Publication #994. U. S. Gov't Printing Office, 1963.
4. Louria, D. B., Stiff, D. P., and Bennett, B.: Disseminated moniliasis in the adult. *Medicine* 41:307-337 (Dec.) 1962.
5. Louria, D. B., Blevins, A., Armstrong, D., Burdick, R., and Lieberman, P.: Fungemia caused by "nonpathogenic" yeasts. *Arch. Intern. Med.* 119:247-252 (Mar.) 1967.
6. Lupin, A. M., Bascomb, H. E. Seabury, J. H., and McGinn, M.: Experience with *Candida* recovered from venous blood. *Antimicrob Agents Chemother.* 1: 10-19, 1961.
7. Smits, B. J., Prior, A. P., and Arblaster, P. G.: Incidence of *Candida* in hospital in-patients and the effects of antibiotic therapy. *Brit. Med. J.* 5481: 208-210 (Jan.) 1966.
8. Braude, A. I., and Rock, J. A.: The syndrome of acute disseminated moniliasis in adults. *Arch. Intern. Med.* 104: 91-100 (July) 1959.
9. Utz, J.: Amphotericin B Toxicity. Combined Clinical Staff Conference at the National Institute of Health. General side effects. *Ann. Intern. Med.* 61: 340-343 (Aug.) 1964.
10. Brandriss, M., Wolff, S. M., Modres, R., and Stohlman, F., Jr.: Anemia induced by amphotericin B. *J.A.M.A.* 189: 663-666 (Aug. 31) 1964.
11. Hill, G.: Amphotericin B. Toxicity. Combined Clinical Staff Conference at the National Institute of Health. Changes in renal morphology. *Ann. Intern. Med.* 61: 349-354 (Aug.) 1964.
12. Relman, A. S., and Swartz, W. B.: The nephropathy of potassium depletion. A clinical and pathological entity. *New Engl. J. Med.* 255: 195-203 (Aug. 2) 1956.
13. Butler, W. T., Bennett, J. E., Alling, D. W., Wertlake, P. T., Utz, J. P., and Hill, G. J., II: Nephrotoxicity of amphotericin B, early and late effects in 81 patients. *Ann. Intern. Med.* 61:175-187 (Aug.) 1964.

Please send reprint requests to Doctor Yanez, Department of Medicine, Wayne County General Hospital, Eloise, Mich. 48132.

Campbell's Soups…
wide variety…for limited appetites

Many people lose interest in food as they grow older. Some of them are fussy eaters—with only a few favorite foods. Others become indifferent to foods—because planning and preparing meals becomes a chore. Here Campbell's Soups can help—for these four very good reasons:

Appeal With a variety of tastes, textures, aromas, and colors, Campbell's Soups can add interest and appetite appeal. And they're easy to eat—ingredients are tender, bite-size. Even patients on special diets will find soups they can enjoy among the more than 50 different varieties available.

Nourishment Campbell's Soups contain selected meats and sea foods, best garden vegetables—carefully processed to help retain their natural flavors and nutritive values.

Convenience Within 4 minutes a bowl of delicious soup is heated and ready to eat.

Economy Campbell's Soups are inexpensive—an important consideration to those whose budgets are limited.

Recommend Campbell's Soups . . . and, of course, enjoy them yourself. Remember, *there's a soup for almost every patient and diet . . . and for every meal.*

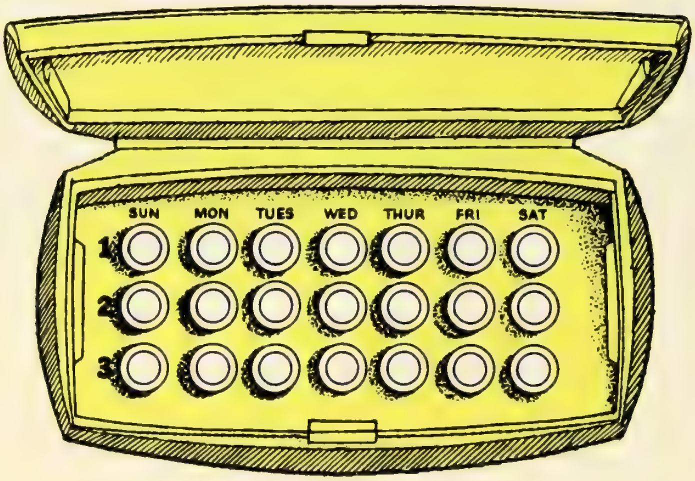
Announcing the half-new p

Dem

What's new:

50 mcg. ethinyl estradiol

. . . Demulen offers added assurance in view of today's concern



What isn't:

1 mg. ethynodiol diacetate

. . . Demulen offers the distinctive Searle progestin proved in millions of women

Demulen—the one oral contraceptive that provides this new combination—offers • A full measure of confidence: Unsurpassed contraceptive effectiveness, and the low estrogen content—50 mcg.—is especially significant today • A full measure of comfort: A low incidence of breakthrough bleeding and other side effects.

Demulen continues the Searle tradition of unmatched convenience. • Sunday starting, cycle after cycle: Three weeks on, one week off. There is no simpler pill-taking schedule. • A package that helps keep her on schedule: The Demulen Compack® tablet dispenser is patient-proof. Day and week of cycle are clearly designated for each tablet.

ulen®

Each tablet contains 1 mg. ethynodiol diacetate/50 mcg. ethinyl estradiol

ons–Demulen acts to prevent ovulation by inhibiting the output of gona-
ins from the pituitary gland. Demulen depresses the output of both the
-stimulating hormone (FSH) and the luteinizing hormone (LH).

ial note: Oral contraceptives have been marketed in the United States
960. Reported pregnancy rates vary from product to product. The effec-
s of the sequential products appears to be somewhat lower than that of
mbination products. Both types provide almost completely effective con-
ion.

ncreased risk of thromboembolic disease associated with the use of hor-
contraceptives has now been shown in studies conducted in both Great
and the United States. Other risks, such as those of elevated blood pres-
ver disease and reduced tolerance to carbohydrates, have not been quan-
with precision.

-term administration of both natural and synthetic estrogens in subpri-
nimal species in multiples of the human dose increases the frequency of
nimal carcinomas. These data cannot be transposed directly to man. The
e carcinogenicity due to the estrogens can be neither affirmed nor refuted
time. Close clinical surveillance of all women taking oral contraceptives
e continued.

cation–Demulen is indicated for oral contraception.

raindications–Patients with thrombophlebitis, thromboembolic disorders,
al apoplexy or a past history of these conditions, markedly impaired liver
n, known or suspected carcinoma of the breast, known or suspected
en-dependent neoplasia and undiagnosed abnormal genital bleeding.

ings–The physician should be alert to the earliest manifestations of
otic disorders (thrombophlebitis, cerebrovascular disorders, pulmonary
ism and retinal thrombosis). Should any of these occur or be suspected
g should be discontinued immediately.

ospective studies of morbidity and mortality in Great Britain and studies
rbidity in the United States have shown a statistically significant associa-
etween thrombophlebitis, pulmonary embolism, and cerebral thrombosis
nbolism and the use of oral contraceptives. There have been three princi-
dies in Britain$^{1-3}$ leading to this conclusion, and one^{4} in this country. The
te of the relative risk of thromboembolism in the study by Vessey and
was about sevenfold, while Sartwell and associates^{4} in the United States
a relative risk of 4.4, meaning that the users are several times as likely to
o thromboembolic disease without evident cause as nonusers. The
can study also indicated that the risk did not persist after discontinuation
inistration, and that it was not enhanced by long-continued administra-
he American study was not designed to evaluate a difference between
cts. However, the study suggested that there might be an increased risk of
oembolic disease in users of sequential products. This risk cannot be
tated, and further studies to confirm this finding are desirable.

ontinue medication pending examination if there is sudden partial or
ete loss of vision, or if there is a sudden onset of proptosis, diplopia or
ne. If examination reveals papilledema or retinal vascular lesions medica-
hould be withdrawn.

e the safety of Demulen in pregnancy has not been demonstrated, it is
mended that for any patient who has missed two consecutive periods
ncy should be ruled out before continuing the contraceptive regimen. If
tient has not adhered to the prescribed schedule the possibility of preg-
should be considered at the time of the first missed period.

nall fraction of the hormonal agents in oral contraceptives has been iden-
in the milk of mothers receiving these drugs. The long-range effect to the
g infant cannot be determined at this time.

autions–The pretreatment and periodic physical examinations should in-
special reference to the breasts and pelvic organs, including a Papanico-
mear, since estrogens have been known to produce tumors, some of them
nant, in five species of subprimate animals. Endocrine and possibly liver
on tests may be affected by treatment with Demulen. Therefore, if such
re abnormal in a patient taking Demulen, it is recommended that they
eated after the drug has been withdrawn for two months. Under the in-
e of progestogen-estrogen preparations preexisting uterine fibromyomas
ncrease in size. Because these agents may cause some degree of fluid retention, conditions which might be influenced by this factor, such as epilepsy, migraine, asthma, cardiac or renal dysfunction, require careful observation. In breakthrough bleeding, and in all cases of irregular bleeding per vaginam, nonfunctional causes should be borne in mind. In undiagnosed bleeding per vaginam adequate diagnostic measures are indicated. Patients with a history of psychic depression should be carefully observed and the drug discontinued if the depression recurs to a serious degree. Any possible influence of prolonged Demulen therapy on pituitary, ovarian, adrenal, hepatic or uterine function awaits further study. A decrease in glucose tolerance has been observed in a significant percentage of patients on oral contraceptives. The mechanism of this decrease is obscure. For this reason, diabetic patients should be carefully observed while receiving Demulen therapy. The age of the patient constitutes no absolute limiting factor, although treatment with Demulen may mask the onset of the climacteric. The pathologist should be advised of Demulen therapy when relevant specimens are submitted. Susceptible women may experience an increase in blood pressure following administration of contraceptive steroids.

Adverse reactions observed in patients receiving oral contraceptives–A statistically significant association has been demonstrated between use of oral contraceptives and the following serious adverse reactions: thrombophlebitis, pulmonary embolism and cerebral thrombosis.

Although available evidence is suggestive of an association, such a relationship has been neither confirmed nor refuted for the following serious adverse reactions: neuro-ocular lesions, e.g., retinal thrombosis and optic neuritis.

The following adverse reactions are known to occur in patients receiving oral contraceptives: nausea, vomiting, gastrointestinal symptoms (such as abdominal cramps and bloating), breakthrough bleeding, spotting, change in menstrual flow, amenorrhea during and after treatment, edema, chloasma or melasma, breast changes (tenderness, enlargement and secretion), change in weight (increase or decrease), changes in cervical erosion and cervical secretions, suppression of lactation when given immediately post partum, cholestatic jaundice, migraine, rash (allergic), rise in blood pressure in susceptible individuals and mental depression.

Although the following adverse reactions have been reported in users of oral contraceptives, an association has been neither confirmed nor refuted: anovulation post treatment, premenstrual-like syndrome, changes in libido, changes in appetite, cystitis-like syndrome, headache, nervousness, dizziness, fatigue, backache, hirsutism, loss of scalp hair, erythema multiforme, erythema nodosum, hemorrhagic eruption and itching.

The following laboratory results may be altered by the use of oral contraceptives: hepatic function: increased sulfobromophthalein retention and other tests; coagulation tests: increase in prothrombin, Factors VII, VIII, IX and X; thyroid function: increase in PBI and butanol extractable protein bound iodine, and decrease in T^3 uptake values; metyrapone test and pregnanediol determination.

References: 1. Royal College of General Practitioners: Oral Contraception and Thrombo-Embolic Disease, J. Coll. Gen. Pract. 13:267-279 (May) 1967. **2.** Inman, W. H. W., and Vessey, M. P.: Investigation of Deaths from Pulmonary, Coronary, and Cerebral Thrombosis and Embolism in Women of Child-Bearing Age, Brit. Med. J. 2:193-199 (April 27) 1968. **3.** Vessey, M. P., and Doll, R.: Investigation of Relation Between Use of Oral Contraceptives and Thromboembolic Disease. A Further Report, Brit. Med. J. 2:651-657 (June 14) 1969. **4.** Sartwell, P. E.; Masi, A. T.; Arthes, F. G.; Greene, G. R., and Smith, H. E.: Thromboembolism and Oral Contraceptives: An Epidemiologic Case-Control Study, Amer. J. Epidem. 90:365-380 (Nov.) 1969.

OA1

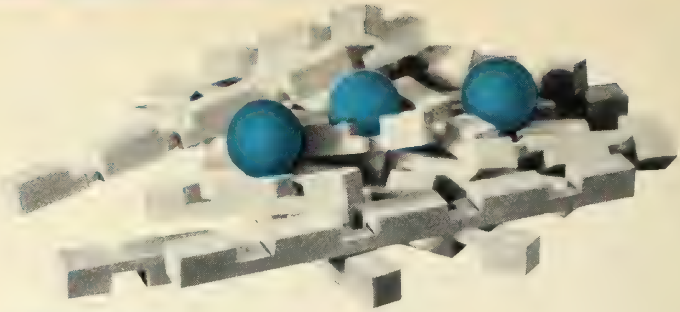
SEARLE Where "The Pill" Began
G. D. Searle & Co., P.O. Box 5110, Chicago, Illinois 60680

half-new
Dem/ulen®

Each tablet contains 1 mg. ethynodiol diacetate/50 mcg. ethinyl estradiol

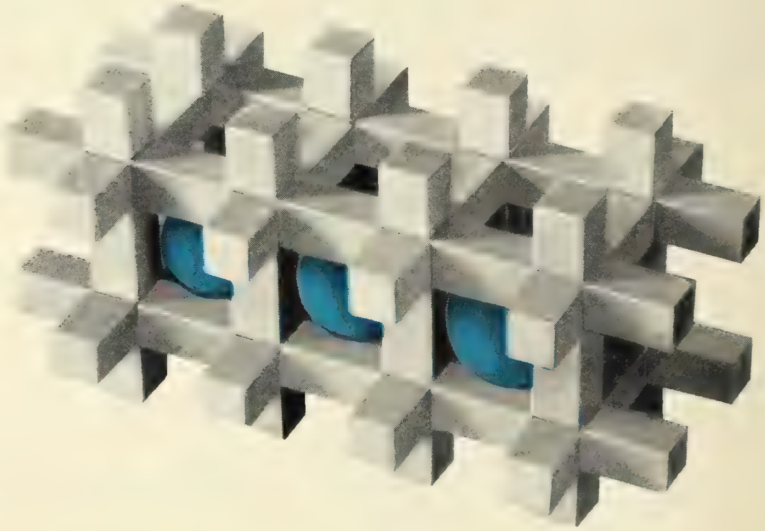
IN G.U. THERAPY

Does not create problems...



SOLVES THEM

WITH FIRST DOSE PAIN RELIEF



Urised is a problem solver; it brings patient comfort with first dose pain relief. Unlike newer antibiotics or sulfonamides, Urised does not create problems. It has a time tested record of minimal side effects. For over 50 years, Urised has created physician and patient confidence by providing effective therapy when needed.

FIRST DOSE PAIN RELIEF

URISED®

For G.U. Frequency—Urgency—Burning

Clinically effective for G.U. Therapy [1-5]

- **CYSTITIS**
- **PYELITIS**
- **TRIGONITIS**
- **URETHRITIS**

Each blue-coated tablet contains these active ingredients:

Atropine Sulfate	0.03 mg.	Methylene Blue	5.4 mg.
Hyoscyamine	0.03 mg.	Phenyl Salicylate	18.1 mg.
Methenamine	40.3 mg.	Benzoic Acid	4.5 mg.

Contraindications: Glaucoma, urinary bladder neck or pyloric obstruction, duodenal obstruction and cardiospasm. Hypersensitivity to any of the ingredients.

Warnings: Do not exceed recommended dosages.

Precautions: Administer with caution to persons with known idiosyncrasy to atropine and cardiac disease. While under this therapy the urine is blue; patients should be so advised to allay apprehension.

Adverse Reactions: Neither irritation nor untoward reactions have been reported; however, if pronounced dryness of the mouth, flushing, or difficulty in initiating micturition occurs, decrease dosage. If rapid pulse, dizziness or blurring of vision occurs, discontinue use immediately. Acute urinary retention may be precipitated in prostatic hypertrophy.

Dosage and Administration: Adults: Two tablets, orally, four times per day, followed by liberal fluid intake. Older children reduce dosage in proportion to age and weight.

How Supplied: Bottles of 100, 500 and 1,000 tablets.

References: (1) Sands, R.X.: New York St. J. Med. 61:2598-2602, 1961: (2) Renner, M.J., et al: Hosp. Topics 39:71-73, 1961: (3) Haas, Jr., J., and Kay L.L.: Southwest. Med. 42:30-32, 1961 (4) Marshall, W.: Clin. Med. 7:499-502, 1960: (5) Strauss, B.: Clin. Med. 4:307-310, 1957.

CONAL MANUFACTURERS OF URICEUTICAL® SPECIALTIES

PHARMACEUTICALS, INC.
CHICAGO, ILLINOIS 60640

MJ-GP-3

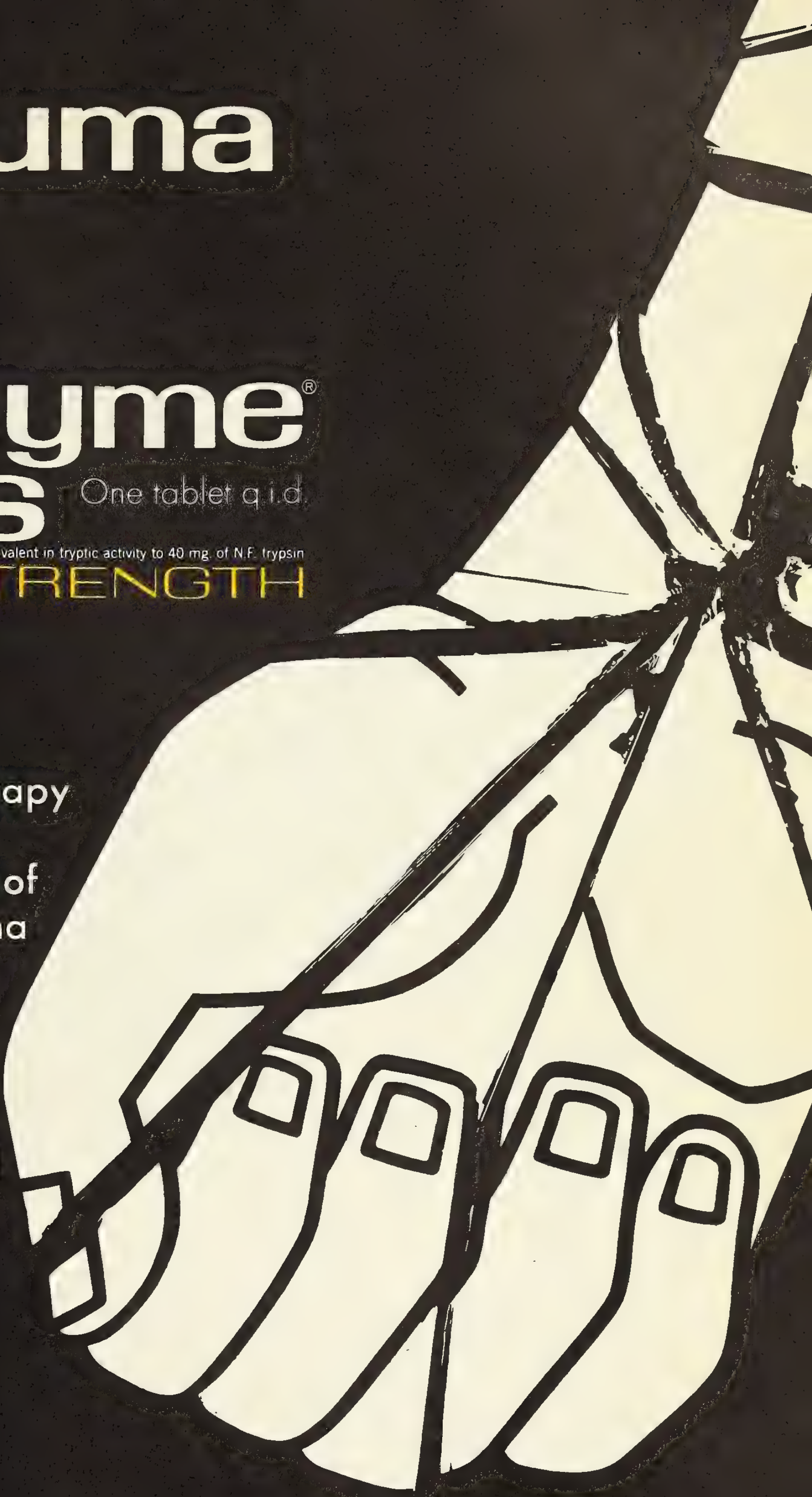
in trauma

new Orenzyme® Bitabs

One tablet q.i.d.

Trypsin: 100,000 N.F. Units, Chymotrypsin: 8,000 N.F. Units.; equivalent in tryptic activity to 40 mg. of N.F. trypsin

DOUBLE STRENGTH



Proteolytic enzyme therapy specifically indicated for the rapid resolution of inflammation and edema as adjunctive therapy in accidental and surgical trauma.

1 tablet q.i.d. provides recommended therapeutic dose at lower cost.

A FULL DAY'S DOSAGE

Description: ORENZYME BITABS offers the therapeutic effects of trypsin in an oral form as adjunctive therapy for the rapid resolution of inflammation and edema. ORENZYME BITABS is convenient to use, promotes patient cooperation and is ideally suited for maintenance therapy following parenteral trypsin.

Indications: When used as adjunctive therapy for the rapid resolution of inflammation and edema, good results have been obtained in:

☐ Accidental Trauma
☐ Postoperative Tissue Reactions.

Other conventional measures of treatment should be used as indicated. In infection, appropriate anti-infective therapy should be given.

Contraindications: ORENZYME BITABS should not be given to patients with a known sensitivity to trypsin or chymotrypsin.

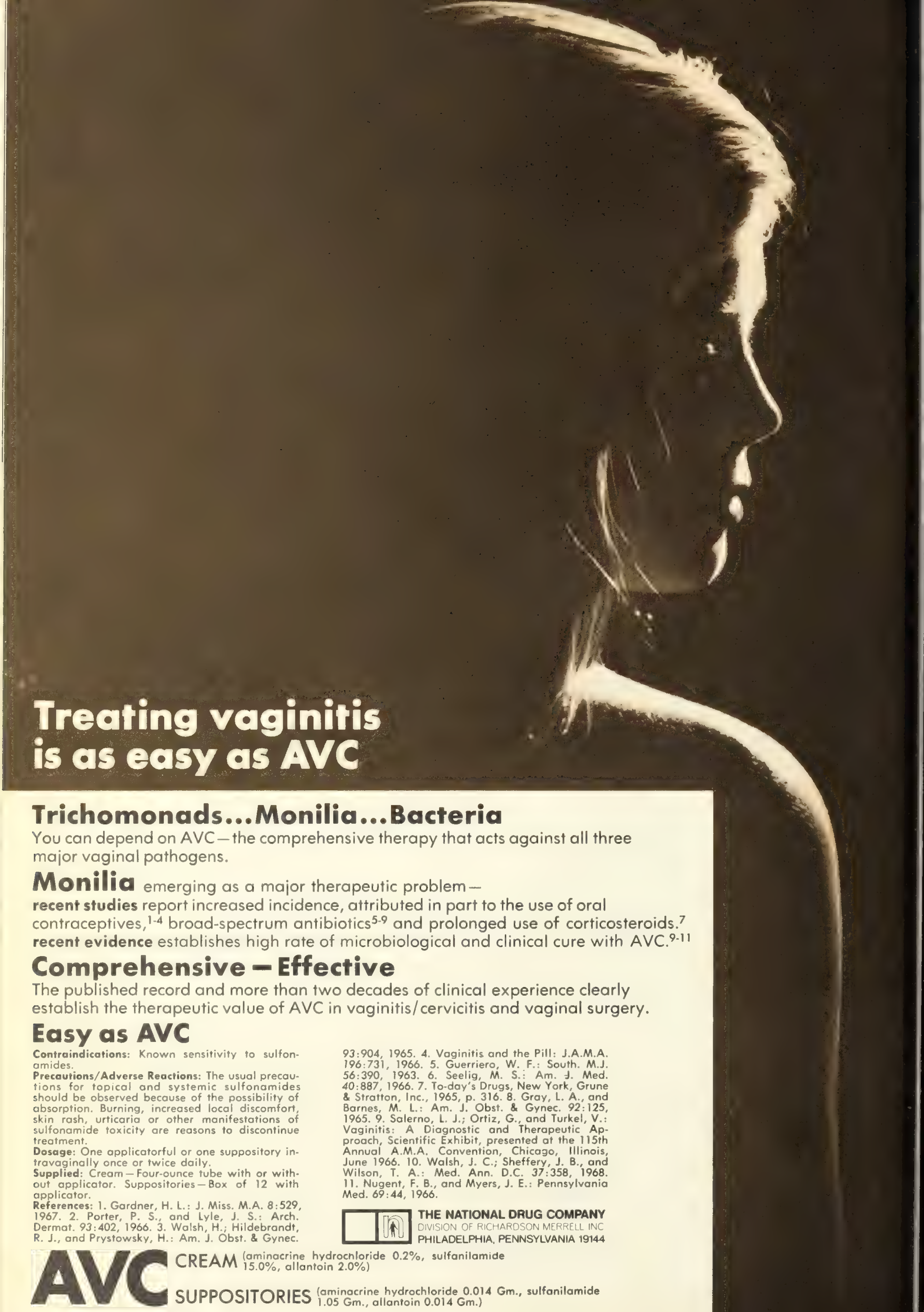
Precautions: It should be used with caution in patients with abnormality of the blood clotting mechanism such as hemophilia, or with severe hepatic or renal disease. Safe use in pregnancy has not been established.

Adverse Reactions: Adverse reactions with ORENZYME have been reported infrequently. Reports include allergic manifestations (rash, urticaria, itching), gastrointestinal upset and increased speed of dissolution of animal-origin surgical sutures. There have been isolated reports of anaphylactic shock, albuminuria and hematuria. Increased tendency to bleed has also been reported but, in controlled studies, it has been seen with equal incidence in placebo-treated groups. (See Precautions.) It is recommended that if side effects occur medication be discontinued.

Dosage: One tablet q.i.d.

THE NATIONAL DRUG COMPANY
DIVISION OF RICHARDSON-MERRELL INC.
PHILADELPHIA, PENNSYLVANIA 19144

TRADEMARK: BITABS U.S. PATENT NO. 3,004,893 4/69 0-821A



Treating vaginitis is as easy as AVC

Trichomonads...Monilia...Bacteria

You can depend on AVC—the comprehensive therapy that acts against all three major vaginal pathogens.

Monilia emerging as a major therapeutic problem—
recent studies report increased incidence, attributed in part to the use of oral contraceptives,[1-4] broad-spectrum antibiotics[5-9] and prolonged use of corticosteroids.[7]
recent evidence establishes high rate of microbiological and clinical cure with AVC.[9-11]

Comprehensive—Effective

The published record and more than two decades of clinical experience clearly establish the therapeutic value of AVC in vaginitis/cervicitis and vaginal surgery.

Easy as AVC

Contraindications: Known sensitivity to sulfonamides.
Precautions/Adverse Reactions: The usual precautions for topical and systemic sulfonamides should be observed because of the possibility of absorption. Burning, increased local discomfort, skin rash, urticaria or other manifestations of sulfonamide toxicity are reasons to discontinue treatment.
Dosage: One applicatorful or one suppository intravaginally once or twice daily.
Supplied: Cream—Four-ounce tube with or without applicator. Suppositories—Box of 12 with applicator.
References: 1. Gardner, H. L.: J. Miss. M.A. 8:529, 1967. 2. Porter, P. S., and Lyle, J. S.: Arch. Dermat. 93:402, 1966. 3. Walsh, H.; Hildebrandt, R. J., and Prystowsky, H.: Am. J. Obst. & Gynec. 93:904, 1965. 4. Vaginitis and the Pill: J.A.M.A. 196:731, 1966. 5. Guerriero, W. F.: South. M.J. 56:390, 1963. 6. Seelig, M. S.: Am. J. Med. 40:887, 1966. 7. To-day's Drugs, New York, Grune & Stratton, Inc., 1965, p. 316. 8. Gray, L. A., and Barnes, M. L.: Am. J. Obst. & Gynec. 92:125, 1965. 9. Salerno, L. J.; Ortiz, G., and Turkel, V.: Vaginitis: A Diagnostic and Therapeutic Approach, Scientific Exhibit, presented at the 115th Annual A.M.A. Convention, Chicago, Illinois, June 1966. 10. Walsh, J. C.; Sheffery, J. B., and Wilson, T. A.: Med. Ann. D.C. 37:358, 1968. 11. Nugent, F. B., and Myers, J. E.: Pennsylvania Med. 69:44, 1966.

THE NATIONAL DRUG COMPANY
DIVISION OF RICHARDSON MERRELL INC
PHILADELPHIA, PENNSYLVANIA 19144

AVC CREAM (aminacrine hydrochloride 0.2%, sulfanilamide 15.0%, allantoin 2.0%)
SUPPOSITORIES (aminacrine hydrochloride 0.014 Gm., sulfanilamide 1.05 Gm., allantoin 0.014 Gm.)

TRADEMARK: A V C AV-919A 7/69

welcome

New Members

Members of the Michigan State Medical Society oin in welcoming the following new members ino a progressive state medical organization. MSMS s dedicated to promoting the science and art of nedicine, the protection of the public health, and he betterment of the medical profession. Each iew member is encouraged to join with other ISMS members at both the local and the state evels in achieving these goals.

Jsha R. Sarda, M.D., Pontiac General Hosp., Seminole at W. Huron, Pontiac 48053
ve M. Schlecte, M.D., 2307 Highland Road, Ann Arbor 48104
erald M. Schmit, M.D., 555 E. William, Ann Arbor 48108
homas Slough, M.D., 301 E. Spruce St., Sault Ste. Marie 49783
avid Transue, M.D., 13403 E. 13 Mile Road, Warren 48093
Villiam G. Tucker, M.D., 1631 Gull Road, Kalamazoo 49001
teven L. Van Riper, M.D., 1490 Iroquois, Detroit 48214
ouglas F. Wacker, M.D., 1323 E. Michigan Ave., Lansing 48912
Villiam Weber, M.D., 1201 Flushing Road, Flint 48504
everly A. Zelt, M.D., Burn Clinic Medical Ctr. PC (Anes.), Petoskey 49770
ahsan Anisoglu, MD, Northville State Hosp., Northville 48167
Vail Basmaji, MD, 19647 Joy Rd., Detroit 48228
Theodore I. Bergman, MD, 7330 W. Seven Mile Rd., Detroit 48221
M. C. Burton, Jr., MD, 315 Richard Terrace, S.E., Grand Rapids 49506
John D. Carey, MD, Henry Ford Hosp., Detroit 48202
James P. Curran, MD, Box A, Kalamazoo State Hosp., Kalamazoo 49001
George T. R. Fahlund, MD, 920 Cherry St., S.E., Grand Rapids 49506
Larry E. Fleischmann, MD, Children's Hospital, Detroit 48202
John A. Geralt, MD, 11420 Mack Ave., Detroit 48214
Aleksandrs Kalnins, MD, 1052 Eastern Ave., N.E., Grand Rapids 49503
Trilok S. Khanna, MD, 25210 Grand River, Detroit 48240
Harvey J. Komorn, MD, 10326 W. Seven Mile Rd., Detroit 48221
Ronald L. Krome, MD, 1326 St. Antoine St., Detroit 48226
Donald F. Larson, MD, 165 Budlong St., Hillsdale 49242
Hector E. Morales, MD, 111 W. Dayton St., Fremont 49412
Marva J. Morris, MD, 12632 Dexter, Detroit 48238
Patrick Murray, MD, 261 Mack Ave., Detroit 48201
Jalal Panah, MD, 2696 Red Fox Trail, Troy 48084
Wm. A. Reynolds, MD, Henry Ford Hospital, Detroit 48202
Michael K. Rosenberg, MD, Sinai Hospital, Detroit 48235
Michael S. Salesin, MD, Sinai Hospital, Detroit 48235
Robert D. Steele, Jr., MD, 5860 Shaun Rd., Orchard Lake 48033
Janusz Subczynski, MD, 3333 E. Jefferson, Detroit 48207
Ronald J. Van Valkenburg, MD, 6850 Division Ave., So., Grand Rapids 49506
Habib Varizi-Nazari, MD, 4400 Orchard Lake Rd., Orchard Lake 48033
Maurice C. Wynes, MD, 331 S. Jefferson, Saginaw 48607

PLAINWELL SANITARIUM, INC.

Plainwell, Michigan

M. Leroy Barry, MD
D. W. Everett, MD
W. R. King, PhD

The Plainwell Sanitarium is a private psychiatric hospital licensed by the Michigan Department of Mental Health and accredited by the Joint Commission on Accreditation of Hospitals. Our extensive diagnostic and treatment services include the following:

- Organic and psychological therapy for the psychiatrically and emotionally disturbed of all ages.
- Diagnostic and psychological evaluation and hospitalization, if indicated, of juveniles for courts and social agencies.
- Rehabilitative services for geriatric and convalescent patients.
- Medico-legal counsel.
- Out-patient services.

685-8441 Admissions
685-5952 Out-patients

msms news

MSMS Committee Issues Statements On TB Testing, Environmental Pollution

The Committee on Public Health has presented to The MSMS Council a statement on environmental pollution and a "suggested schedule for the active immunization of infants and children for tuberculin testing." Both items were approved by The Council at its March 11 meeting.

They are as follows:

Statement on Environmental Pollution

The Michigan State Medical Society strongly backs the current efforts being made in the fight to improve our environmental health. As physicians and citizens we realize the urgent necessity in curbing environmental pollution whatever its origin.

We lend our support to all agencies charged with the control of environmental pollution such as the Water Resources Commission, Michigan Department of Public Health, the Michigan Department of Natural Resources, etc.

We believe any legal means should be utilized to obtain maximum compliance with the statutes protecting us from undue water pollution, air contamination, improper solid waste disposal, and noise pollution.

Suggested Schedule For The Active Immunization Of Infants And Children — Tuberculin Testing

1st visit 2-3 months*	1st dose DTP *TYPE I OPV or TRIVALENT OPV***
2nd visit 4-6 weeks later	2nd dose DTP *TYPE III OPV (or TRIALENT OPV optional)*
3rd visit 4-6 weeks later	3rd dose DTP *TYPE II OPV or TRIVALENT OPV*
11 months	Tuberculin test
12-24 months****	DTP 4th dose (supporting) *TRIVALENT OPV* Measles vaccine (Rubeola) Smallpox (primary vaccination) Mumps vaccine Rubella vaccine (German Measles)
5 years	Tuberculin test *** DTP Booster — *TRIVALENT OPV* Smallpox revaccination Measles, mumps or rubella vaccine if indicated
10 years	(Tuberculin test — Smallpox revaccination desirable)
15 years	DT Booster Tuberculin test Smallpox revaccination — OVER 6 YEARS OF AGE— — No Previous Protection—

---

* Protection against pertussis should start early and can be initiated at 4-6 weeks with single antigen pertussis vaccine. Pertussis vaccine is not generally recommended beyond age 5 years.

** For Salk (inactivated vaccine) protection against polio and for use of combinations of Salk with DTP or TD consult manufacturers' recommendations.

*** More frequent tuberculin tests may be desirable and in some instances are required for group participation.

**** See copy "Simultaneous Administration of Live Virus Vaccines" (Morbidity and Mortality, Vol. 18, No. 22, week ending May 31, 1969.) Consult manufacturers' recommendations.

(Continued on Page 598)

ACHROCIDIN

chrocidin® Tablets and Syrup

etracycline HCl—Antihistamine—Analgesic Compound

ach tablet contains: ACHROMYCIN® Tetracycline HCl 125 mg.; Phenacetin 120 mg.; Caffeine 30 mg.; Salicylamide 150 mg.; Chlorothen Citrate 25 mg.

CHROCIDIN Tetracycline HCl—Antihistamine—Analgesic Compound Tablets and Syrup are recommended for the treatment
f tetracycline-sensitive bacterial infection which may complicate vasomotor rhinitis, sinusitis and other allergic diseases of the
pper respiratory tract, and for the concomitant symptomatic relief of headache and nasal congestion. For children and elderly
atients you may prefer caffeine-free ACHROCIDIN Syrup. Each 5 cc contains: ACHROMYCIN Tetracycline equivalent to
etracycline HCl 125 mg.; Phenacetin 120 mg.; Salicylamide 150 mg.; Ascorbic Acid (C) 25 mg.; Pyrilamine Maleate 15 mg.

ontraindications: Hypersensitivity to any
mponent.
arning: In renal impairment, since liver tox-
ity is possible, lower doses are indicated; dur-
g prolonged therapy consider serum level
terminations. Photodynamic reaction to sun-
ght may occur in hypersensitive persons.
otosensitive individuals should avoid expo-
re; discontinue treatment if skin discomfort
curs.
ecautions: Drowsiness, anorexia, slight gas-
c distress can occur. In excessive drowsi-
ss, consider longer dosage intervals. Persons
on full dosage should not operate vehicles. Nonsusceptible organisms may overgrow; treat superinfection appropriately. Treat beta-hemolytic streptococcal infections at least 10 days to help prevent rheumatic fever or acute glomerulonephritis. Tetracycline may form a stable calcium complex in bone-forming tissue and may cause dental staining during tooth development (last half of pregnancy, neonatal period, infancy, early childhood).

Adverse Reactions: *Gastrointestinal*—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. *Skin*—maculopapular and erythematous rashes; exfoliative dermatitis; photosensitivity; onycholysis, nail discoloration. *Kidney*—dose-related rise in BUN. *Hypersensitivity reactions*—urticaria, angioneurotic edema, anaphylaxis. *Intracranial*—bulging fontanels in young infants. *Teeth*—yellow-brown staining; enamel hypoplasia. *Blood*—anemia, thrombocytopenic purpura, neutropenia, eosinophilia. *Liver*—cholestasis at high dosage.

Upon adverse reaction, stop medication and treat appropriately.

Lederle LEDERLE LABORATORIES, A Division of American Cyanamid Company, Pearl River, New York 10965

534-9

DIPHTHERIA	DT (Adult type)
TETANUS	Two doses not less than one month apart. Third dose (supporting) six months to one year later or Three doses at not less than two-months' intervals
POLIO	Trivalent OPV — **two doses** given at least eight weeks apart followed in one year with a **third** dose.

Consider possible need for measles, mumps and rubella vaccines.

MICHIGAN DEPARTMENT OF PUBLIC HEALTH
Division of Epidemiology 8/12/69

School Health Activities Of MSMS Included In New AMA Report

MSMS members will be interested in the report about the Michigan State Medical Society in the new survey report published by the AMA of "School Health Activities of State Medical Association." The booklet carries the following report about MSMS:

"The following committees are concerned with school health activities: Child Welfare, Family Life and Sex Education, Eye Care, Alcohol and Drug Dependence, and the Committee on Medical Aspects of Organized Athletics.

"Current projects include a pilot project to establish better communications with local residents in Oakland County about school health problems, a program for prevention of blindness and for preschool hearing and vision testing, a dyslexia project in Lansing, the promotion of comprehensive health courses in schools, family life and sex education programs in schools, and the establishment of a medical eye care program for Michigan's Crippled Children Program.

"The committees work with the Michigan Department of Health, the Michigan Crippled Children Commission and the Michigan Department of Public Education."

Established 1924

MERCYWOOD HOSPITAL

4038 Jackson Road
Conducted by Sisters of Mercy
Ann Arbor, Michigan
Telephone — 313 663-8571

Mercywood Hospital is a private neuropsychiatric hospital licensed by the Michigan Department of Mental Health. Mercywood specializes in intensive, multi-disciplinary treatment for emotional and mental disorders.

Accredited by the Joint Commission on Accreditation of Hospitals and the National League of Nursing. A full Blue Cross participating hospital.

Certified for: Medicare and M.A.A. programs

PSYCHIATRIC STAFF

Lyle M. Allis, M.D.
Robert J. Bahra, M.D.
Dean P. Carron, M.D.
Francis M. Daignault, M.D.
Gordon C. Dieterich, M.D.
James R. Driver, M.D.
Stuart M. Gould, Jr., M.D.
Leonard E. Himler, M.D.*
Sydney Joseph, M.D.
Jacob J. Miller, M.D.
Rudolf Nobel, M.D.
Richard D. Watkins, M.D.
Stephen C. Mason, M.D.
Philip M. Margolis, M.D.
Hubert Miller, M.D.

* 1904 - 1967

Members Urged to Read, Study Proposed MSMS Constitution Changes

The following proposed amendments to the MSMS Constitution will come before the MSMS House of Delegates at the 1970 Annual Session in Detroit. All MSMS members are urged to read and study them to be able to act accordingly.

The 1969 House of Delegates proposed two constitutional amendments which must be published to all members. These are:

1. Article X — The Council, Section 1 — Composition — Powers and Duties:
   "The Council shall be the executive body of the Society. It shall consist of one Councilor from each Councilor District or one Councilor for each ten delegates when the number of delegates from the district exceeds ten, the President, President-Elect, Immediate Past President, SECRETARY, TREASURER, Speaker and Vice Speaker of the House of Delegates. It shall have the custody and entire control of all funds and property of the Society and shall act for the Society as a whole and for the House of Delegates between sessions. THE SECRETARY AND TREASURER SHALL BE DULY ELECTED FOR THREE YEARS BY THE HOUSE OF DELEGATES, AFTER NOMINATION BY THE COUNCIL AND/OR THE HOUSE."
2. Article II, Purposes, Section 1 — Purposes — The purposes of this Society shall be:

   (1) To bring into one viable, effective organization the ethical physicians, licensed to practice in Michigan, in order that their contribution to human welfare will be enhanced.

   (2) To constitute, support and assist the American Medical Association in cooperation with similar societies of other states, in meeting its appropriate responsibilities and in like fashion, to form constituent and component medical societies.

   (3) To conceive, develop and administer health educational programs designed to improve public understanding, awareness and acceptance of good medical standards, practices and concepts, as they relate to personal health, scientific progress and society's advancement.

   (4) To stimulate advancement of the science and art of medicine, and continually to seek to advance the medical, scientific, social, environmental, economic and political knowledge of its members in order that the doctor may better serve his patients and the public health generally.

   (5) To aid Michigan physicians individually and collectively in maintaining high levels of ethical conduct and standards of practice to protect and serve the total public.

   (6) To work with other medical and nonmedical groups and persons through individual members and as a corporate body toward stimulating progress in all aspects of health care in Michigan and elsewhere, thereby offering leadership toward meeting the health needs of the people.

   (7) To preserve voluntary medical practice, recognizing it as a most effective means of delivering quality health care.

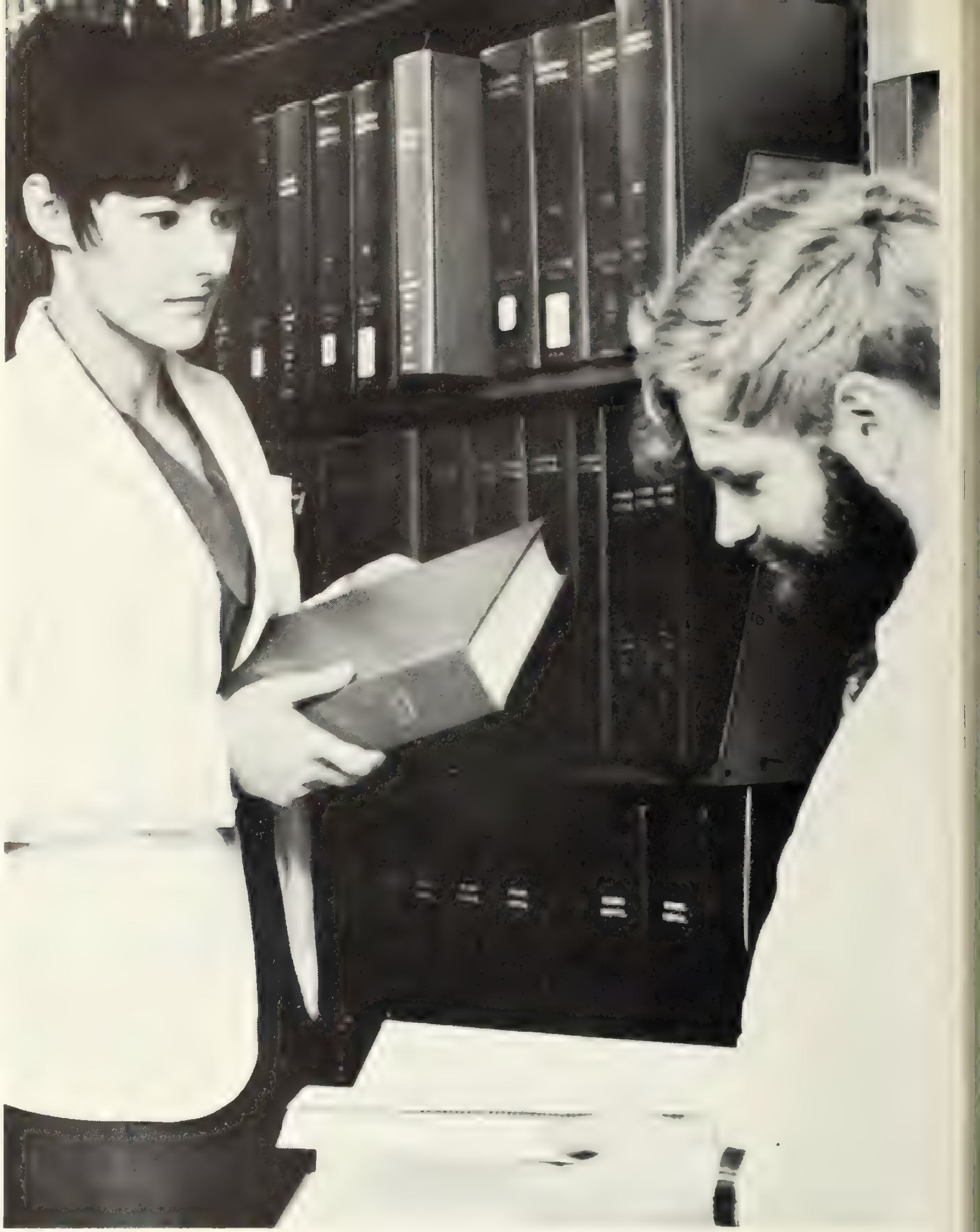
   (8) To develop methods, techniques and practices that moderate the costs of quality medical and health care and provide for fair remuneration for services rendered.

   (9) To ensure the future of medical practice by attracting capable people into the medical and health professions and help arrange for the most effective distribution of their services.

   (10) To encourage medical students and physicians-in-training to participate in, understand, and help develop the purposes and goals of organized medicine in order that the total objectives of the profession be enhanced and accomplished.

   (11) To combat the efforts of all those who would denigrate the reputation and services of the medical profession.

   (12) To carry on such functions and activities as are deemed necessary or desirable to accomplish effectively the above purposes; provided, however, that the Society shall engage in no activities which cannot be construed as relevant, incidental, or necessary to its charitable, educational, or scientific purposes.



MSMS Donates Magazines To MSU Medical Library

OVER 500 POUNDS of medical magazines, back issues which have accumulated at MSMS from as far back as 10 years, were recently donated by MSMS to the growing medical library at Michigan State University. Many of them are now bound, on the shelves and available for students like Clare and Tom Morley, above, husband-and-wife team both in their second year of medical school at MSU.

MSU MEDICAL LIBRARIAN Margaret Thorpe sees "what goodies we have" as the back journals are loaded from the MSMS headquarters building into her car. She has been head medical librarian since 1961 at MSU and supervises a section of the larger MSU science library.

ANOTHER BOX of magazines is loaded for delivery to the MSU library. There the MSMS donations filled gaps in incomplete sets of magazines, helped create a second, reserve set of other titles and stocked smaller medical libraries in classroom buildings on campus.

AMONG THE TITLES transferred from MSMS headquarters to the library at MSU by Maynard Hoover, MSMS productions director, Mrs. Thorpe and Miss Roberts, were **Journal of the American Medical Association, Medical Economics, Michigan Medicine** and the **Detroit Medical News.**

THE BACK ISSUES first accumulated on the shelves of the MSMS library, then were transfered to the MSMS Headquarters basement. Mrs. Thorpe and her assistant, Nicki Roberts, inspect some of the issues currently on the MSMS library shelves, which may become available to them at a later date.

Michigan Mediscene

July 12 — Michigan Society of Internal Medicine, 11 a.m., MSMS Headquarters, East Lansing

July 15 — MSMS Judicial Commission, 2 p.m., MSMS Headquarters, East Lansing

July 17 — Michigan Association of Regional Medical Programs, Board Meeting, 1:30 p.m., MSMS Headquarters, East Lansing

July 23-25 — MSMS Midsummer Session of The Council, Grand Hotel, Mackinac Island

July 26 — Michigan Chapter of the American Association of Medical Assistants, Board Meeting, noon, MSMS Headquarters

July 30-31 — 50th Annual Coller-Penberthy-Thirlby Medical Conference, Park Place Motor Inn, Traverse City

Sept. 20 — MSMS Council, Sheraton-Cadillac Hotel, 9:30 a.m.

Sept. 20-24 — MSMS Annual Session, Sheraton-Cadillac Hotel, Detroit

Sept. 23 — MSMS Council, Sheraton-Cadillac Hotel, Detroit, 8 a.m.

Sept. 22-24 — 44th Annual Convention of Woman's Auxiliary to MSMS, Pontchartrain Hotel, Detroit

Sept. 26-27 — Annual Fall Educational Seminar, Michigan Chapter, American Association of Medical Assistants, Weber's Inn, Ann Arbor

Oct. 5-9 — 53rd Annual Meeting, American Dietetic Association, Detroit

Oct. 5-19 — MSMS Orient Adventure

Oct. 16-17 — Michigan State Association of Industrial Nurses Fall Conference, Holiday Inn, St. Joseph

Nov. 4 — Special meeting of The Council, MSMS Headquarters, East Lansing, noon

Nov. 9-13 — International Drug Abuse Symposium sponsored for practicing physicians by the University of Michigan, Towsley Center, Ann Arbor

Nov. 11 — Michigan Cancer Coordinating Committee, MSMS Headquarters, East Lansing, noon

Nov. 29-Dec. 2 — Many Michigan physicians will participate in the annual AMA Clinical Convention in Boston

Dec. 9 — MSMS Council, MSMS Headquarters, East Lansing, 9:30 a.m.

Increase Practice Control Through MANAGEMENT By

Modern office and financial management offers realistic methods toward achievement of personal life goals. A logical outcome of PM's services is the attainment of your objectives.

OBJECTIVES

- More Time for Patient
- More Time for Leisure
- Better Collection Control
- Better Cost Control
- Assistance With Financial Planning
- Identify Business Problems
- Seek Best Solutions to Problems

PROFESSIONAL MANAGEMENT • FOR PHYSICIANS AND DENTISTS
PM
since 1932

PROFESSIONAL MANAGEMENT
Black and Skaggs Associates, Inc.
Battle Creek, Michigan

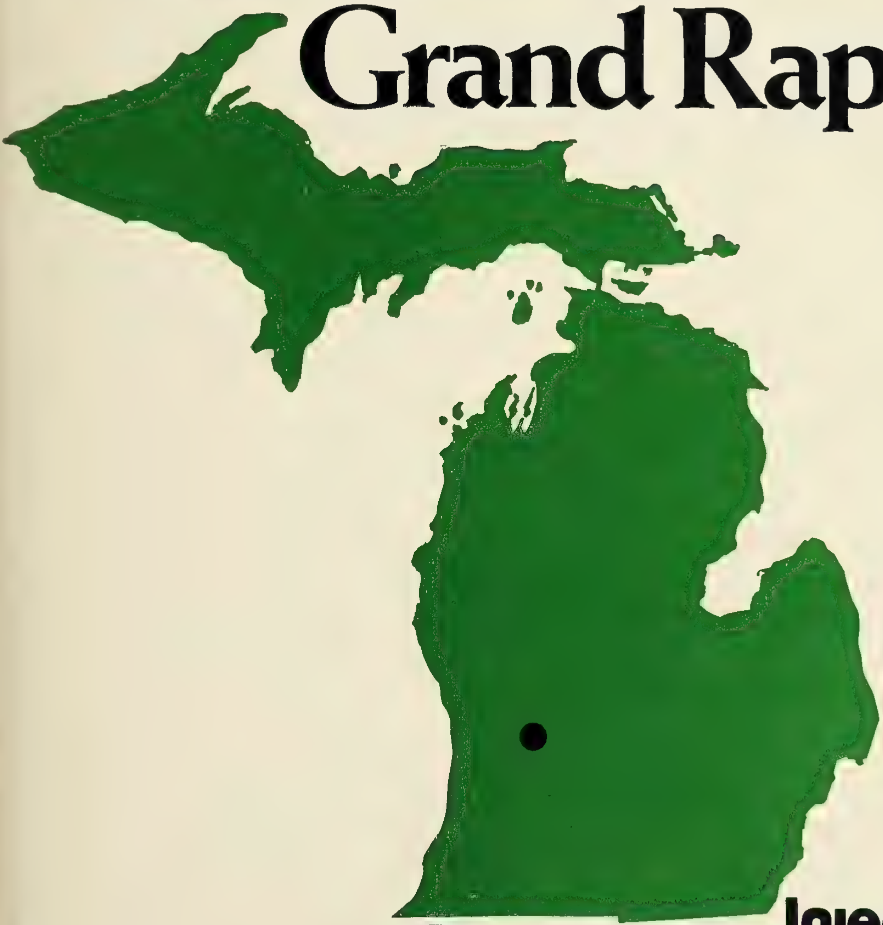
Serving Michigan Physicians

Offices in these cities
Ann Arbor - Battle Creek - Berkley - Detroit - Flint
Grand Rapids - Lansing - Muskegon - Saginaw - Traverse City

Schering

After only one year:

Administered to more people than live in Grand Rapids.*



Injectable

Garamycin®

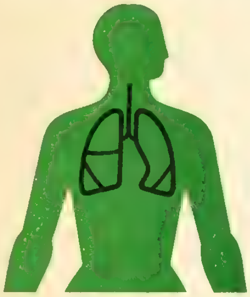
brand of gentamicin sulfate injection

*An estimated 208,000 patients have received GARAMYCIN Injectable to date. The population of Grand Rapids is 205,000. (Estimated 1969 figure from The New York Times Encyclopedic Almanac 1970.)

See Clinical Considerations section on last page...

Mounting acceptance in the hospital...

Proven clinical effectiveness



Respiratory Infections

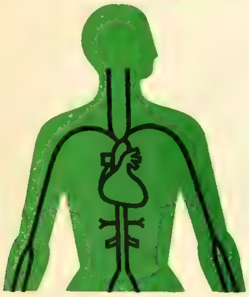
Outstanding results in serious gram-negative respiratory infections[1,2]

GARAMYCIN Injectable may prove successful where other antibiotics have failed.

Urinary Tract Infections

Strikingly effective in selected urinary tract infections[3]

With relatively low intramuscular doses, the promptly attained levels of GARAMYCIN achieved in the urine are considerably higher than the concentrations required for effectiveness against virtually all susceptible gram-negative pathogens. (Appropriate precautions are indicated in patients with impaired renal function; consult Package Insert for full details.)



Septicemia

May be lifesaving[4-6]

Numerous investigators have drawn attention to the value of GARAMYCIN Injectable in the treatment of gram-negative septicemias, often complicated by shock. Many hospital strains of *Serratia* are susceptible.[6]

Wounds and Burns

Response may be dramatic in wounds and burns complicated by sepsis[7]

The established efficacy of GARAMYCIN Injectable against *Pseudomonas*—as well as most other gram-negative pathogens—makes it an especially useful agent in the treatment of infected wounds and burns.

Important Precautionary Note Patients receiving treatment with GARAMYCIN Injectable (gentamicin sulfate injection) should be under close clinical observation because of the toxicity associated with the use of the drug. Ototoxicity, vestibular and auditory, can occur in patients, primarily those with preexisting renal damage, treated with GARAMYCIN Injectable for longer periods or with higher doses than recommended.

GARAMYCIN Injectable is potentially nephrotoxic, and this should be kept in mind when it is used in patients with preexisting renal damage.

This drug should be limited to the treatment of serious infections caused by susceptible gram-negative bacteria, with due regard for relative antibiotic toxicity. (See Clinical Considerations section.)

Mounting evidence in the laboratory...

Over 95% gram-negative pathogens sensitive.*

No other antibiotic performed comparably *in vitro* against gram-negative pathogens.

In a nationwide culture audit of antibiotic sensitivity patterns, sensitivity reports from 106 hospitals, geographically representative by census tract and of varying sizes, were analyzed. During the three-month period, ***every*** gram-negative culture slip from ***every*** hospital was surveyed. The total number of cultures involved in the audit was 97,091. The total number of sensitivity determinations was 643,503.

Antibiotics*

Percentage of sensitive strains
Number of strains tested

Pathogens	Garamycin	Kanamycin	Cephalothin	Cephaloridine	Ampicillin	Colistimethate	Chloramphenicol	Tetracycline
Klebsiella pneumoniae	**99.5%** 962	**84.7%** 992	**86.2%** 995	**76.1%** 67	**32.7%** 1,020	**96.3%** 640	**82.9%** 1,028	**77.1%** 1,026
Aerobacter aerogenes	**95.9%** 2,739	**86.1%** 2,818	**53.5%** 2,985	**58.8%** 1,514	**22.7%** 3,066	**88.6%** 2,603	**85.8%** 3,071	**67.8%** 2,981
Klebsiella aerobacter group	**98.8%** 566	**83.9%** 547	**66.1%** 522	**60.5%** 276	**28.0%** 553	**89.5%** 560	**86.2%** 587	**62.8%** 433
Klebsiella, all others	**92.7%** 2,944	**83.3%** 3,186	**77.4%** 2,976	**67.5%** 627	**13.5%** 2,883	**95.0%** 2,105	**81.6%** 3,212	**70.6%** 3,063
Pseudomonas aeruginosa	**91.6%** 4,528	**29.8%** 4,460	**6.6%** 4,418	**6.6%** 1,279	**6.0%** 4,360	**91.3%** 3,852	**26.9%** 4,608	**26.4%** 4,404
Proteus, indole-positive	**91.8%** 1,031	**85.8%** 1,062	**39.9%** 981	**54.1%** 364	**40.2%** 1,042	**10.3%** 758	**76.1%** 1,096	**42.1%** 1,051
Proteus mirabilis, indole-negative	**94.9%** 3,272	**90.1%** 3,378	**83.1%** 3,290	**77.5%** 975	**78.0%** 3,274	**8.8%** 2,634	**85.9%** 3,469	**26.8%** 3,278
Proteus, unspecified	**96.2%** 1,335	**85.8%** 1,371	**71.7%** 1,434	**70.0%** 647	**64.7%** 1,435	**11.2%** 1,233	**76.0%** 1,421	**22.4%** 1,298
Escherichia coli and all other *Escherichias*	**96.4%** 12,557	**91.4%** 12,818	**87.8%** 12,686	**88.8%** 4,251	**74.6%** 12,899	**95.4%** 10,623	**94.1%** 13,086	**70.0%** 12,559
Paracolobactrum, all	**93.4%** 303	**88.9%** 325	**62.0%** 305	**74.2%** 62	**43.8%** 340	**80.9%** 215	**87.1%** 350	**72.6%** 340
Coliform bacteria	**99.0%** 593	**91.2%** 649	**81.5%** 637	**66.7%** 21	**52.7%** 624	**95.6%** 607	**91.6%** 678	**76.1%** 637
Totals	**95.1%** 30,830	**80.5%** 31,606	**65.3%** 31,229	**68.1%** 10,083	**50.3%** 31,496	**75.8%** 25,829	**79.7%** 32,606	**56.5%** 31,070
Gram-positive (included for consistency with Package Insert, not an approved indication)								
Staph—*S. aureus*, coagulase-positive	**97.4%** 1,548	**88.8%** 1,458	**97.7%** 2,050	**98.7%** 636	**61.1%** 1,559	**20.4%** 628	**94.4%** 2,123	**83.7%** 1,966
Staph—*S. aureus*, unspecified	**99.3%** 993	**92.8%** 902	**98.1%** 1,289	**95.3%** 213	**45.8%** 1,153	**29.3%** 116	**96.4%** 1,427	**82.3%** 1,360

*Adapted from a three-month, nationwide hospital audit by R. A. Gosselin and Co., Inc., Dedham, Massachusetts (mid-May to mid-August, 1969).[8] Antibiotics with significant gram-negative spectra are included. Organisms are listed as reported by laboratory.

Sensitivity testing was done by the disc method, a generally reliable test in the hospital setting. It should be noted, however, that the results with GARAMYCIN were somewhat higher than the results reported where the tube dilution technique was used. (See Clinical Considerations section which follows.) The concentration of the GARAMYCIN disc was 10 mcg.

Whereas standard testing methods were used by all hospitals, it is acknowledged that in a survey of this kind considerations such as differences in methodology are possible sources of error. The comparative percentage-sensitivity results derived from a survey of this kind are, therefore, not absolute. One should keep in mind also that the proper selection of an antibiotic is based not only on susceptibility testing but on relative toxicity and other clinical considerations as well.

It is felt, nonetheless, that the broad scope of the survey and the extreme care in data collection and tabulation permit a conclusion that the results are *generally* representative of current nationwide antibiotic sensitivity patterns.

Injectable
Garamycin®
brand of
gentamicin sulfate injection

See Clinical Considerations section on last page...

Injectable
Garamycin®
gentamicin sulfate injection

ADULT DOSAGE GUIDELINES

See definitive prescribing information in Package Insert.

Patients with Normal Renal Function

Total Daily Dose (administered in two, three, or four divided doses)			
	Less Severe	**Resistant/ Moderately Severe**	**Serious/ Life-Threatening**
Urinary Tract Infections (due to susceptible strains of gram-negative bacteria)†	0.8-1.2 mg./kg. for 7-10 days	Larger doses or additional antibacterial therapy should be considered in severe urinary tract infections or in resistant cases involving the renal parenchyma or anatomic anomaly.	**up to 5 mg./kg.**
Other Infections including bacteremia, infected surgical wounds, severe soft tissue infections, and respiratory tract infections (due to susceptible strains of gram-negative bacteria)	3 mg./kg. for 7-10 days		

†Alkalinization of the urine may be a useful therapeutic adjunct.

Patients with Impaired Renal Function

To minimize the risk of ototoxicity in patients with impaired kidney function, only the first dose should be that normally recommended. Each subsequent dose should be half or less of that recommended for patients with normal renal function, depending upon the degree of renal impairment.

In patients with renal failure who are undergoing 14-hour hemodialysis twice weekly, administration of 1 mg./kg. GARAMYCIN Injectable at the end of each dialysis period has been suggested.

Clinical Considerations

Indications: GARAMYCIN Injectable is clinically effective in infections due to susceptible strains of gram-negative bacteria, including *Pseudomonas aeruginosa*, and species of indole-positive and indole-negative *Proteus*, *Escherichia coli*, and *Klebsiella-Aerobacter*. Bacteriologic studies should be conducted to identify the causative organism and to determine its sensitivity to gentamicin sulfate. Sensitivity discs of the drug are available for this purpose. If the susceptibility tests indicate that the causative organism is resistant to gentamicin sulfate, other appropriate antibiotic therapy should be instituted.

IN VITRO INHIBITION OF CLINICALLY IMPORTANT BACTERIA BY GENTAMICIN SULFATE (TUBE DILUTION STUDIES)

		No. of Strains (%) Inhibited by:				
BACTERIA	No. of Strains Tested	4 mcg./cc. or less		8 mcg./cc. or less*		No. of *In Vitro* Studies
Staphylococcus aureus	1,210	1,200	(99%)	1,206	(99%)	11
Pseudomonas aeruginosa	885	771	(87%)	828	(93%)	16
Escherichia coli	836	736	(88%)	779	(93%)	11
Indole-positive and indole-negative *Proteus* species	477	210	(44%)	358	(75%)	12
Klebsiella-Aerobacter species	292	205	(70%)	231	(79%)	10

*Number of strains (%) of gram-negative bacteria inhibited by 10 mcg./cc. or less are as follows: *Pseudomonas aeruginosa*, 828 (93%); *Escherichia coli*, 792 (95%); *Proteus* species, 393 (82%); *Klebsiella-Aerobacter* species, 284 (97%). From same studies as above.
Source: Package Insert

This drug should be limited to the treatment of serious infections caused by gram-negative bacteria, particularly *Pseudomonas aeruginosa*, *Proteus* and other susceptible organisms, with due regard for relative antibiotic toxicity. Therefore, the drug should be considered for use against gram-negative: 1. Bacteremia; 2. Infected surgical wounds; 3. Severe soft tissue infections, including burns complicated by sepsis; 4. Respiratory tract infections; and 5. Selected cases of urinary tract infection.

Contraindications: GARAMYCIN Injectable is contraindicated in individuals with a history of hypersensitivity or toxic reactions to gentamicin.

Warnings: Patients receiving treatment with GARAMYCIN should be under close clinical observation because of the toxicity associated with the use of this drug. Ototoxicity, vestibular and auditory, can occur in patients, primarily those w pre-existing renal damage, treated with GARAMYCIN Injecta usually for longer periods or with higher doses than recommenc

GARAMYCIN Injectable is potentially nephrotoxic, and t should be kept in mind when it is used in patients with pre-exist renal impairment. Kidney function diminished by infection of upper urinary tract may, however, improve during effective tre ment with GARAMYCIN Injectable.

Concurrent administration of potentially ototoxic drugs such streptomycin and kanamycin or of potentially nephrotoxic dr such as polymyxin, colistin, and kanamycin with gentamicin sulf has not been shown to afford any clinical advantages and, moreo may result in additive toxicity. Monitoring of vestibular, cochl and renal function will provide guidance for therapy in such ca

Precautions: In patients with impaired renal function in wh serious infection develops, serum concentrations of the drug n rise, with consequently increased risk of ototoxicity. In these tients or in those in whom recommended dosage or duration therapy must be exceeded as a life-saving measure, routine stu of kidney function should be performed when possible. These n be supplemented by evaluation of the vestibular and auditory fu tion and measurement of serum concentration of the drug wl feasible. Serum concentrations of gentamicin should be maintai below the range of 10-12 mcg./ml. to reduce risk of ototoxicity.

Ordinarily, treatment should not be given for more than 7 to days or be repeated unless required for serious infection not sponsive to other agents.

As with other antibiotics, treatment with GARAMYCIN Injecta may occasionally result in overgrowth of nonsensitive organisms superinfection occurs, appropriate therapy is indicated.

Safety for use in pregnancy or the potential for fetal ototoxicity nephrotoxicity have not been established. Studies in pregnant mals have not revealed teratogenic or ototoxic effects in the fe GARAMYCIN Injectable should not be used in pregnant patient in women of childbearing age unless its use is deemed advisa by the physician.

Adverse Reactions: The overall incidence of ototoxicity conside related to treatment with GARAMYCIN Injectable was 2.8 per c (16 of 565 patients). Contributory factors (two or more factors w relevant to most patients) were as follows: 10 had azotemia, received a total of 1 gram or more of the drug, 7 had recently ceived other potentially ototoxic antibiotics (streptomycin or ka mycin), and 5 were over 60 years of age. Six also had decrea high-tone hearing acuity, which returned to or toward normal the 4 patients retested.

Analysis of BUN data indicated that 4 (2%) of 172 patients sho increases in BUN that were probably related to treatment w GARAMYCIN Injectable. Of 20 increases probably or possibly rela to treatment, 7 were reversible, 9 occurred in terminal patients, 4 had no follow-up.

Other adverse reactions associated with treatment were one insta each of urticaria, decreased hematocrit, and reversible depress of granulocytes with normal bone marrow. Other rarely repo and possibly treatment-related adverse reactions were anemia, creased reticulocyte count, rash, purpura, drug fever, hypotens convulsions, twitching, salivation, nausea, vomiting, increased tr aminase activity (SGOT or SGPT), increased serum bilirubin, creased serum calcium, and joint pain.

Packaging: GARAMYCIN Injectable, 40 mg./cc., 2-cc. multiple- vials, for intramuscular administration.

References: (1) Brayton, R. G., and Louria, D. B.: Gentamici gram-negative urinary and pulmonary infections, Arch. Int. M *114*:205, 1964.* (2) Louria, D. B.; Young, L.; Armstrong, D., Smith, J. K.: Gentamicin in the treatment of pulmonary infecti J. Infect. Dis. *119*:483, 1969. (3) Cox, C. E.: Gentamicin, a aminoglycoside antibiotic: Clinical and laboratory studies in uri tract infections, J. Infect. Dis. *119*:486, 1969. (4) Groll, E.: Clin experience with gentamicin, data from 12 German clinics, in tamicin: First International Symposium, Paris, January Lucerne, Essex Chemie AG, pp. 121-128.* (5) Jackson, G. G.: Lab tory and clinical investigation of gentamicin, *ibid.*, pp. 62-74. Medeiros, A. E.: Discussion, J. Infect. Dis. *119*:533, 1969. (7) Polk, Discussion, J. Infect. Dis. *119*:529, 1969. (8) Three-month, nation hospital audit by R. A. Gosselin and Co., Inc., Dedham, Massachus (mid-May to mid-August, 1969).

*Dosage in this investigational study was less than now recommen in Package Insert.

For more complete prescribing details, consult package inser Physicians' Desk Reference. Schering literature is also avail from your Schering Representative or Medical Services Departm Schering Corporation, Union, New Jersey 07083.

AHFS CATEGORY 8:12.28

medicolegal

LIBEL OF OSTEOPATHS BY LANDLORD NOT PROVED

(The following article is quoted from the AMA CITATION NEWSLETTER of Jan. 1, 1970, prepared by the AMA Law Department.)

A landlord's statement that he had leased office space to "competent medical doctors not osteopaths," was not libel in itself. In order to recover damages, the osteopaths would have to show a personal reference to them and an inference of incompetence in the statement, a Michigan appellate court held.

During the term of their lease, the osteopaths vacated the leased premises and stopped the payment of rent. Just prior to leaving the premises, the osteopaths erected a sign in front of the building announcing their intended move. The landlord's son, who was a dentist with offices in the building removed the sign. The son then demanded of the osteopaths the keys to their offices. The osteopaths contended that the son was authorized by his father to make this demand, and that therefore, the landlord was the first party to breach the lease. The court ruled that since the facts surrounding the son's actions were disputed at the trial, it was improper for the judge to instruct the jury that, as a matter of law, the son was not acting as the agent of the landlord.

Eight months after the osteopaths vacated the premises, and two months after the landlord instituted suit, the landlord mailed 200 cards to the public containing the allegedly libelous statement. The court ruled that because the statement did not refer to the osteopaths personally, on its face, and because it did not impugn the professional ability of the osteopaths, they would have to establish such personal reference and inference of incompetence. — *Ardash* v. *Karp*, 170 N.W.2d 854 (Mich., June 26, 1969) from Vol. 20, No. 6

(Editor's Note: The following article is quoted from the AMA CITATION newsletter of March 1, 1970, prepared by the AMA Law Department.)

HOSPITAL LIABLE FOR RESTRAINT OF PATIENT ATTEMPTING ESCAPE

Damages of $5,500 were awarded against a hospital for restraining a patient from departing with-

BRIGHTON HOSPITAL

A non-profit foundation

FOR ALCOHOLISM

Member, Michigan Hospital Association, American Hospital Association

A facility designed to rehabilitate and aid the compulsive drinker in arresting his addiction.

Brighton Hospital meets the standards established by the Michigan State Board of Alcoholism and is recommended by that Board.

12851 East Grand River
One block south of I-96 at Kensington Rd. Exit
four miles east of U. S. 23
Brighton, Michigan
ACademy 7-1211

(A 16-m.m. sound color film on Brighton Hospital is available for free loan to qualified groups.)

out authority to do so. The patient had suffered a compression fracture of the spine from a fall while attempting to escape.

The patient had been physically restrained by hospital personnel when he attempted to leave late at night. Such restraint had not been ordered by his attending physician and there was no contention that he was legally insane or dangerous to others or to himself.

The patient had voluntarily entered the hospital for treatment of a heart condition. After three days in the coronary unit he was transferred to a semiprivate room shared by an elderly man who was confused and out of contact with reality. Dissatisfied with this situation, he dressed and attempted to leave the hospital without consulting anyone. He was caught at the exit by an attendant and was physically forced to return to the room, where he was tied to the bed with a long belt at the direction of a nurse. The nurse had not first consulted any physician.

The patient managed to get himself untied and tried to use the belt to escape from the room, which was on the second floor. The belt was too short and he fell about four feet, landing on his buttocks and suffering a fracture of the second lumbar vertebra. He was returned to the hospital and given treatment for the fracture, but he was left with a permanent injury requiring use of a cane.

In awarding damages, the trial court said, "Our jurisprudence places a very high value on personal freedom and one who would restrain another in the exercise of his freedom, be it of mind or body, must find sufficient reason in law to do so." It held that there was no legal justification in this case, since the patient was not insane and not a danger to anyone, including himself. It said that contributory negligence is not a defense.

The court held that the measure of damages included injury to peace, happiness and feelings, nervousness, emotional distress and the actual physical injury arising from the physical restraint and the injury sustained in trying to escape. Since the patient had not been billed for the hospital care or medical care in treatment of the fractured spine, that expense was not included in the damages.

The court also said this was not a case for exemplary damages, since the improper conduct of the hospital personnel was not so reckless or wanton as to be without explanation or excuse.—*Smith v. Henry Ford Hospital,* Cir. Ct., Wayne Co., (Mich., Jan. 7, 1970) (Reference: L. S. Charfoos, Esq., 939 First National Bank Bldg., Detroit, Mich. 48226)

from Vol. 20, No. 10

CONSTIPATION
EVACUATE GENTLY

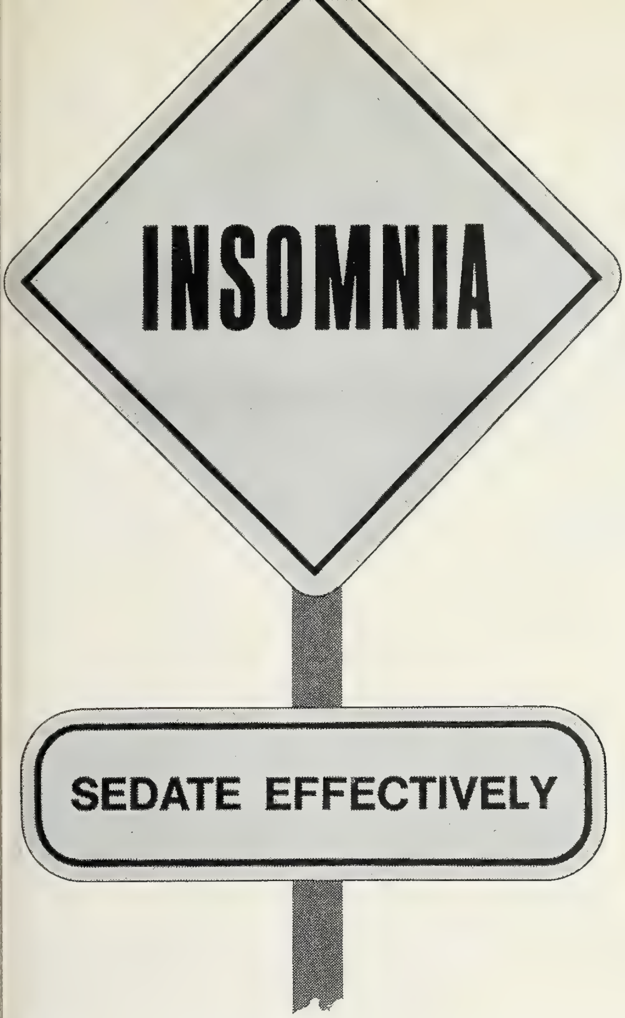
With EVAC-U-GEN — your patients with functional constipation can evacuate gently. Because EVAC-U-GEN has a mild laxative action and tends to cause the stool to be soft — it is highly desirable for those sensitive to harsh laxatives — particularly children, pregnant women, and geriatric patients. Recommend EVAC-U-GEN for the management of functional constipation. It is highly effective. Non-griping. Chewable. Very palatable. Economical.

EVAC-U-GEN®

A highly-flavored and palatable tablet of yellow phenolphthalein, bismuth subcarbonate, bismuth subgallate in special base. Chewable. Bottles of 35 and 100. Adult Dose: Chew 1 or 2 tablets night or morning. Children (up to age 10): 1/2 tablet. A citrus drink taken with tablet will stimulate action.
PRECAUTION: Do not use when symptoms of appendicitis are present and discontinue use if skin rash appears. Dependence on laxatives can result from continued use.

W-C PRECISION PHARMACEUTICALS

SEND FOR SAMPLES.
WALKER, CORP & CO., INC.
Syracuse, New York 13201



With QUĪ-A-ZONE — you can sedate effectively. A balanced combination of short, intermediate, and long-acting barbiturates (totaling 100 mg.) in a rapidly disintegrating tablet — sedation is provided within a few minutes . . . followed by sound restful sleep . . . usually without morning hangover. The four barbiturates in QUĪ-A-ZONE have dual channels of elimination (renal and hepatic) to lessen metabolic burden, decrease barbiturate retention, and minimize depression.

QUĪ-A-ZONE™

Each rapidly-disintegrating tablet contains 25 mg. secobarbital, 25 mg. pentobarbital, 25 mg. butabarbital, and 25 mg. phenobarbital. Bottles of 100.
Usual Adult Dose: 1 to 2 tablets before retiring.
PRECAUTION: Should not be administered to patients sensitive to barbiturates, or in cases of known previous addiction. Warning: May be habit forming.

W-C PRECISION PHARMACEUTICALS

SEND FOR SAMPLES.

WALKER, CORP & CO., INC.
Syracuse, New York 13201

ancillary

Four Michigan Doctors' Achievements Recognized In Hospital Contest

Four Michigan physicians were cited in the 11th Annual Search for New Hospital Achievements Contest co-sponsored during the 1969-70 year by the Michigan Hospital Association and Michigan Blue Cross. It is estimated that $15 million have been saved Michigan hospitals through the entries submitted and judged over the years in the contest.

Thomas B. Coles, Jr., M.D., director of the Outpatient Department, The Grace Hospital, Detroit, was recognized this year for his hospital's innovation of dispensing free drugs given to the hospital from the pharmacy.

Paul W. Rowe, M.D., radiologist and chief technician at Mercy Hospital, Bay City, was singled out for his suggestion to save $1,000 per year by automating the barium mixing operation in the X-ray department.

The suggestion of Steven J. Figiel, M.D., radiologist at The Grace Hospital, was to utilize all diagnostic rooms first thing in the morning, eliminating the delay in waiting for orderlies to transport patients.

Joseph C. Honet, M.D., chief, Division of Rehabilitation Medicine, Sinai Hospital of Detroit, devised a new progress note and order form for record keeping for both the in-patient charts in the division of rehabilitation medicine, and departmental records.

Michigan TB Ass'n Launches Public 'Kick the Habit' Campaign

The Michigan TB and Respiratory Disease Association has joined the national promotional campaign to help the American public "Kick the Habit" and quit smoking.

Over 21 million Americans have stopped smoking, approximately 840,000 in Michigan, yet more would stop if they had a good reason, says the national association. Thus they are encouraging more to "Kick the Habit."

Michigan Song To Be Utilized By National Council

A four-stanza song developed by Michigan Blue Cross and Blue Shield to promote health careers was recently taped by the National Health Council, Inc., New York City, for distribution to its 85 member councils.

The national council assists the Michigan Health Council and other councils throughout the country. The councils, in turn, will distribute the tapes to local radio stations. Following is the complete text of the song:

Time to wonder, time to know
What will you do?
Searching for a way to go
A job just right for you.

Because the world is full of pain
Health careers exist
We need technicians, nurse's aides,
And others who assist.

Take the opportunity
To serve in your community.
Help yourself, and those in need
Through a health career.

Health careers of many kinds
Important work to do
Are waiting if you'd like to find
A job in need of you.

MICHIGAN HEART ASSOCIATION SPONSORING TWO FALL 'CARDIOLOGY KICKOFFS'

The Michigan Heart Association this year is presenting a double "Cardiology Kickoff" — two Saturdays with a football game in the afternoon and cardiology seminars in the morning. Physicians are urged to register early, with tickets to be distributed on a first-come, first-serve basis for the sellout games.

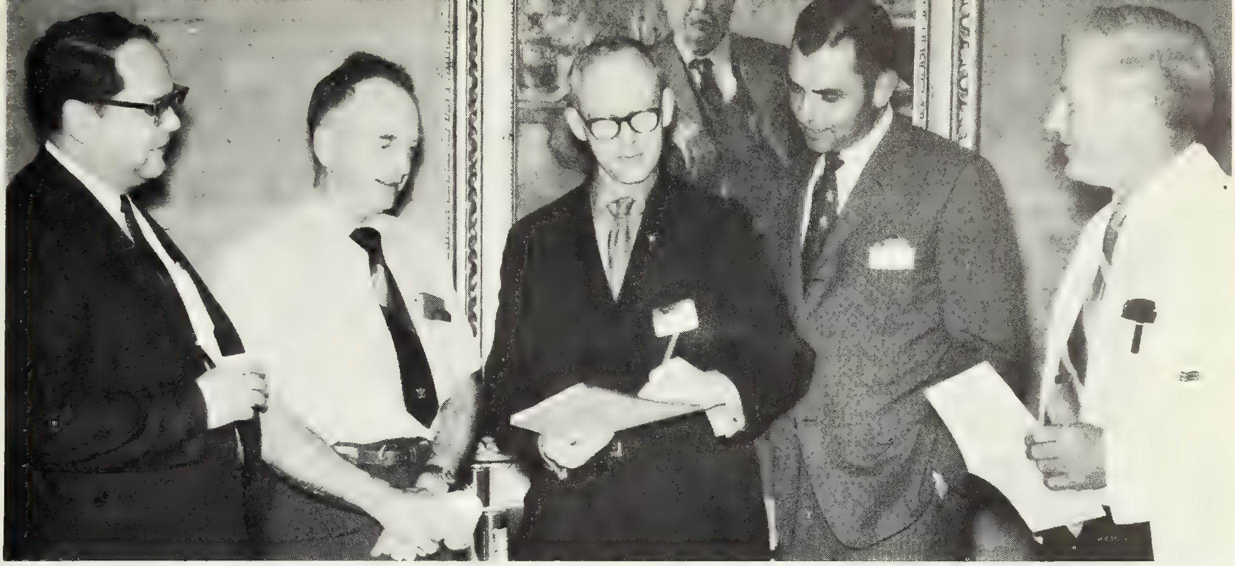
The kickoffs are scheduled Oct. 10 in East Lansing, for the Ohio vs. Michigan State game, and Oct. 17 at Ann Arbor, for the University of Michigan vs. Michigan State game. The fee of $25 per game includes the seminar, lunch, a bus to and from the stadium and ticket; $9 more will include the physician's wife.

Further information may be obtained through Kenneth Haver, Michigan Heart Association, 13100 Puritan, Detroit, Mich.

Specialized Service
IN
PROFESSIONAL LIABILITY INSURANCE
is a high mark of distinction
THE
MEDICAL PROTECTIVE COMPANY
FORT WAYNE, INDIANA
Professional Protection Exclusively since 1899

DETROIT OFFICE: G. A. Triplett, R. K. Wind and J. K. Galloway, Representatives
27200 Lahser Road, Southfield 48075 Telephone: (Area Code 313) ELgin 3-4848 or 444-1439

GRAND RAPIDS OFFICE: G. J. Haworth, Representative
422 Federal Square Building, Grand Rapids 49502 Telephone: 616-454-4477



Gerald O'Connor, M.D., second from right, was chairman of the 1970 MSMS Conference on the Medical Aspects of High School Sports. Doctor O'Connor, University of Michigan team doctor, watches as J. Lindsay McLean, third from left, U-M trainer and conference speaker, makes a point in a discussion with Robert E. Anderson, M.D., far left, Ann Arbor; James G. Hunt, second from left, retired U-M trainer, and Dorin L. Hinerman, M.D., far right, Ann Arbor.

Slides were used effectively by Reed O. Dingman, M.D., right, during his conference presentation about "Management of the Acute Facial Injuries in Contact Sports." Doctor Dingman, University of Michigan medical school professor of plastic surgery, answers a question from Robert H. Evans, M.D., and Jack Grant, center, team physician and coach, respectively, from Sturgis.

Speakers and conference participants sign in and get their name badges at the University of Michigan for the annual conference. Left to right are Walter Kanicki, Bay City High School trainer and conference panelist; Tom McShannock, Muskegon coach; William E. Newell, Purdue University trainer and speaker, and Vern Norris, assistant director of the Michigan High School Athletic Association.

Scenes of 1970 MSMS Sports-Medicine Meeting

C. Ross Hume, M.D., Detroit, right, member of the MSMS conference committee, greets two fellow team doctors — Thomas Green, M.D., left, Detroit, and R. J. Rogers, M.D., Vicksburg. More than 200 team doctors, coaches, and trainers attended the 1970 conference at the University of Michigan Towsley Conference Center April 30.

county societies

Bay Physicians Instrumental In New 'Crisis Line'

"The physicians in our medical society feel strongly that we should be involved in community affairs," says John W. Grigg, M.D., Bay City, secretary of the Bay-Arenac-Iosco County Medical Society. "Neither are we members of 'the silent majority.' "

Two major activities of the Bay area doctors prove his point.

Early this year, the medical society, concerned with rising local drug abuse, called a meeting of community leaders. They formed a committee which has developed a 24-hour emergency telephone service now called "Hotline." It is manned 24 hours a day by volunteers, many of them physician's wives and many with psychiatric training.

Advertised with posters in youth centers and in the local newspapers, the "Hotline" number can be reached anytime by youths with drug or other problems. Over 200 calls were answered in the first week of operation during April, and many culminated in referrals to psychiatrists, family physicians or other interested doctors.

Area physicians on the community drug abuse committee are Hugh K. Cook, M.D., president of the Bay-Arenac-Iosco County Medical Society, James Davis, M.D., and Allen Moore, M.D., all of Bay City.

A similar operation, providing a "crisis center" which youth may go to, as well as an emergency telephone service, is "The Other Room," which counts local physician, Allen Moore, M.D., on its board of directors.

Sponsored by the Bay County Adult Mental Health Clinic, (the "Hotline" is sponsored by the Bay Area Child Guidance Center) "The Other Room" is also designed to help the troubled young person define his problems and to assist him in seeking proper professional help. It began operation May 11.

Kalamazoo Physicians Advised About Drugs

The advice to members of the Kalamazoo Academy of Medicine concerned with drug abuse by local youngsters, was to 1) keep drug education matter-of-fact, 2) praise the child's smallest success rather than berate him for his failures, and 3) keep your sense of balance and proportion — don't panic. The physicians' advisor was Alan K. Done, M.D., associate pediatrician and director of the Poison Center, University Hospital, University of Utah Medical Center, who discussed "The Pharmacology of Substance Abuse" at a recent academy meeting.

Kent Doctors Work With Youth

Volunteer physicians from the Kent County Medical Society gave camp examinations to disadvantaged children free of charge each Monday evening beginning April 20 and continuing through June 29. In charge of arranging the physician examination sessions was John R. Wilson, M.D., a county society member.

Kent medical society members have also presented $25 annual cash awards to four students with deserving entries in the Kent County Science Fair. Exhibits were judged by Youn S. Kim, M.D., and Anna H. Broecker, M.D., who represented the medical society at the awards ceremony.

Expectant Parents Classes Sponsored by Delta Doctors

Members of the Delta-Schoolcraft Medical Society from in and around Escanaba have followed the lead of many other Michigan physicians and are sponsoring a series of seven informal classes for expectant parents. William A. LeMire, M.D., member of The MSMS Council, and the obstetrician-gynecologist for the Escanaba area, teaches the first class, about male and female anatomy. Succeeding classes, on pregnancy, on labor and delivery, baby care, breast feeding, family planning and a tour of the hospital, are taught by registered nurses.

Lenawee Physicians Tour New Health Facility

Members of the Lenawee County Medical Society recently toured their county's newest health care facility. In charge of the tour were the facility administrator, Mr. Les Froman, and Charles Heffron, M.D., who will be on the health care facility staff.

HEW Wants Medicare-Medicaid Changed

By Herbert Mehler, Staff Assistant
MSMS Committee on
Governmental-Medical Care Programs

Far-reaching implications for the health field were outlined by the Department of Health, Education and Welfare in closed-door testimony to the U.S. House Ways and Means Committee and in subsequent public statements. It is reported that the objective is to use the vast power of the federal purse to gradually force radical changes in American medicine by creating new systems of health care to compete with individual M.D.s and hospitals for the nation's health dollar. In brief, the proposals are:

(1) Medicare "Part C," would give the elderly a choice between their existing Medicare benefits and a broader type of government-subsidized protection — if a prepaid group plan is available in their community. This Plan would put federal government in a position of providing preventive medicine such as periodic exams and immunizations. The basis of the proposal would be optional prepaid insurance plans provided contractually and it is intended to foster development of nonprofit, prepaid group medical practice.

(2) That Congress force States to dismantle all legal barriers to nonprofit group practice or any other form of health delivery. States failing to take action by 1973 would be denied Federal Medicaid funds and States would be penalized for prohibiting corporate practice of medicine.

HEW wants Congress to grant it authority to permit the government to contract for group pre-payment plans for treatment of Medicaid patients.

(3) Urges Congress to authorize broader authority for the government to experiment with cost-control innovations in Medicaid, including state-wide experiments. Could require all M.D.s and other health providers to participate in an experimental plan, unless 20% could show they could be caused undue hardship. Compulsion could be used only in experiments in which providers were reimbursed on the basis of "reasonable cost."

(4) Medicare law denies prepayment group plans any share of savings gained if their elderly enrollees on an average require less costly hospitalization than do other Medicare beneficiaries — the new proposal would give group practice plans share of savings.

Cornerstone of these new options on federal health purchasing will be the opportunity for consumers to choose between alternatives with the ultimate goal to give every beneficiary of Medicare and Medicaid the choice of obtaining services from health maintenance organizations or from individual M.D.s and hospitals.

* * *

Medical societies are urged to read the fine print of universal national health insurance proposals. As an example, the N.Y. State Medical Society voted to seek state legislation with certain guidelines, but after careful perusal the Society pressed for defeat.

One of the objections discovered was that if a patient goes to a prepaid medical group, he will receive full coverage. If he chooses private M.D.s it would cost $50 deductible and 20% co-payment.

Seven regional lay boards would recommend fees. State health insurance corporation would approve fees and set premiums. M.D.s may not comprise more than 25% of hospital board or health service corporations, or 40% of medical expense indemnity corporations. Certain specialists — anesthesiologists, radiologists and pathologists — would be paid only for work done in hospitals and M.D.s services in emergency rooms would be considered a hospital's service. M.D. would not be paid unless he is hospital employee. The N.Y. Society said in summary "it is consumer control over economics of medicine on a unilateral basis. It attempts to channel M.D.s into Kaiser or HIP type of closed panel group practice. It is discriminatory."

(Source: Medical News Report, Issues of April 6, 13 and 20, 1970)

Recent Medicare Rulings

The Social Security Administration has ruled on the level of care required in an extended care facility before the facility is entitled to payment under Medicare as follows:

> A woman walking with difficulty due to her cerebral vascular accident was assisted in her daily living activities by an extended care facility. The services did not amount to skilled care on a continuing basis but were merely custodial and therefore not reimbursable under Medicare.
>
> A woman required special feeding techniques by an extended care facility but otherwise cared for herself with little help. Reimbursement was disallowed because the special feeding services were only custodial.
>
> Prohibition against the disclosure of medical information regarding a beneficiary's competency to manage his benefits.
>
> Limitation of hospital insurance benefits in a case of a patient who had two successive impairments within one "spell of illness."
>
> *(Source: Prentice-Hall Report Bulletin No. 22)*

State Comprehensive Health Planning Actions

Approved the contract and work program for health manpower between the Office of Comprehensive Health Planning and the University of Michigan.

Council endorsed H.B. 4554 (Mich.) for the establishment of ten regional health occupation training centers and endorsed future legislation to increase state support for medical and osteopathic schools training programs.

Recommended Advisory Council members be appointed for staggered periods and approved staffs recommendations for modifying Council composition and recommended that membership be not less than thirty-two and not more than forty.

Approved revised Program for Comprehensive Health Planning, FY 1970 and its transmittal to HEW which included a recommendation for the Advisory Council obtaining own staff and consulting services by contract.

Recommended that dental care be included as an element of Comprehensive Health Services and transmitted for consideration to Task Force on Health Care Costs, Organization of Delivery of Services.

Joined a federal health team from HEW Regional Office in a site visit to Model Cities in Lansing to determine whether through the Model Cities Project it would be possible to coordinate federal funding.

OCHP recommended planning grant for Capitol Area Comprehensive Health Planning Association and extension of three months for AHOC (Detroit).

Task Force on Health Care Costs, Organization and Delivery of Services discussed a project initiated by Northville State Hospital for providing comprehensive mental health services to an area in northwest Detroit.

At the first meeting of the Task Force on Health and the Environment suggested issues were Drug Abuse, Disposal of Solid Waste, Disposal of Sewage, Air Pollution, Water Pollution, Land Management, Food Quality & Quantity, Noise, Housing, Transportation, Pesticides, and Over-Population.

Task Force on Health Manpower analyzed the Work Program for Health Manpower Studies, FY 1971 and considered the exploration of foundation grants.

The Academy of Comprehensive Health Planners attended by Doctor Padilla, Acting Director, and Mrs. Yudashkin, staff, considered the federal Administration Bill "The Health Services Improvement Act of 1970" which was supported by the Academy.

Last December a joint memorandum (Interagency Cooperative Issuance No. 70-4) by eight federal agencies encouraged the coordination and linkage of the Cooperative Area Management Planning System (CAMPS) and CHP programs at the local levels for strength and development of health manpower programs.

Doctor Padilla and Mrs. Yudashkin attended a staff meeting at the request of the Division for Services by the Mentally Ill of the Department of Mental Health to identify problems and find possible solutions to apparent conflicts between the requirements for areawide comprehensive health planning agencies and Act 54 Boards.

On May 4, 1970 Governor Milliken replied to a letter from the CHP Commission and Advisory Council which recommended development of legislation of franchising health facilities. He replied "I propose to give strong consideration to this recommendation within the framework of the need for improving the capacity of health care systems and the urgency to make health services more effective yet more capable of meeting the health needs of the people of this State."

(Source: Staff Report to CHP Advisory Council Members, April 22, 1970)

The girth control pill

epanil® Ten-tab

(continuous release form)

(diethylpropion hydrochloride)

vorks on the appetite
not on the 'nerves'

When girth gets out of control, TEPANIL can provide sound upport for the weight control program you recommend. TEPANIL reduces the appetite—patients enjoy food but eat ess. Weight loss is significant—gradual—yet there is a relaively low incidence of CNS stimulation.

ontraindications: Concurrently with MAO inhibitors, in patients hypersensitive to his drug; in emotionally unstable patients susceptible to drug abuse.

Varning: Although generally safer than the amphetamines, use with great caution in atients with severe hypertension or severe cardiovascular disease. Do not use durng first trimester of pregnancy unless potential benefits outweigh potential risks.

dverse Reactions: Rarely severe enough to require discontinuation of therapy, unleasant symptoms with diethylpropion hydrochloride have been reported to occur n relatively low incidence. As is characteristic of sympathomimetic agents, it may ccasionally cause *CNS effects* such as insomnia, nervousness, dizziness, anxiety, and jitteriness. In contrast, CNS depression has been reported. In a few epileptics an increase in convulsive episodes has been reported. *Sympathomimetic cardiovascular effects* reported include ones such as tachycardia, precordial pain, arrhythmia, palpitation, and increased blood pressure. One published report described T-wave changes in the ECG of a healthy young male after ingestion of diethylpropion hydrochloride; this was an isolated experience, which has not been reported by others. *Allergic phenomena* reported include such conditions as rash, urticaria, ecchymosis, and erythema. *Gastrointestinal effects* such as diarrhea, constipation, nausea, vomiting, and abdominal discomfort have been reported. Specific reports on the hematopoietic system include two each of bone marrow depression, agranulocytosis, and leukopenia. A variety of miscellaneous adverse reactions have been reported by physicians. These include complaints such as dry mouth, headache, dyspnea, menstrual upset, hair loss, muscle pain, decreased libido, dysuria, and polyuria.

Convenience of two dosage forms: TEPANIL Ten-tab tablets: One 75 mg. tablet daily, swallowed whole, in midmorning (10 a.m.); TEPANIL: One 25 mg. tablet three times daily, one hour before meals. If desired, an additional tablet may be given in midevening to overcome night hunger. Use in children under 12 years of age is not recommended.

T-006A / 1/70 / U.S. PATENT NO. 3,001,910

THE NATIONAL DRUG COMPANY
DIVISION OF RICHARDSON-MERRELL INC.
PHILADELPHIA, PENNSYLVANIA 19144

Painful night leg cramps...

unwelcome bedfellow for any patient—including those with arthritis, diabetes or PVD

One thing patients can sleep without, particularly patients with chronic disease conditions such as arthritis, diabetes or PVD, is painful night leg cramps. Although seldom the presenting complaint, night leg cramps can tie your patients up in painful knots. Now, just one tablet of QUINAMM at bedtime can usually bring an end to shattered sleep and needless suffering. Your patients will sleep restfully—gratefully—with QUINAMM, specific therapy to prevent painful night leg cramps.

Prescribing Information—Composition: Each white, beveled, compressed tablet contains: Quinine sulfate, 260 mg., Aminophylline, 195 mg. **Indications:** For the prevention and treatment of nocturnal and recumbency leg muscle cramps, including those associated with arthritis, diabetes, varicose veins, thrombophlebitis, arteriosclerosis and static foot deformities. **Contraindications:** QUINAMM is contraindicated in pregnancy because of its quinine content. **Precautions/Adverse Reactions:** Aminophylline may produce intestinal cramps in some instances, and quinine may produce symptoms of cinchonism, such as tinnitus, dizziness, and gastrointestinal disturbance. Discontinue use if ringing in the ears, deafness, skin rash, or visual disturbances occur. **Dosage:** One tablet upon retiring. Where necessary, dosage may be increased to one tablet following the evening meal and one tablet upon retiring. **Supplied:** Bottles of 100 and 500 tablets.

THE NATIONAL DRUG COMPANY
DIVISION OF RICHARDSON-MERRELL INC.
PHILADELPHIA, PENNSYLVANIA 19144

Quinamm™ Specific therapy for night leg cramps
(quinine sulfate 260 mg., aminophylline 195 mg.)

LEADING MANUFACTURER
INSULIN SYRINGES

B-D

TON, DICKINSON AND COMPANY
HERFORD, NEW JERSEY 07070

FREE CLINICAL SUPPLY

PLASTIPAK
INSULIN SYRINGE/NEEDLE UNITS

Send samples to:

Name ______________________
(Physician's Signature

Address ______________________

City ____________ State ____________ Zip ____________

Clip out postcard on dotted line . . . no stamp required

ow you can lower the risk of nsulin error when your patient is ome . . . and alone

B-D

SINGLE-USE
PLASTIPAK
INSULIN SYRINGE/NEEDLE UNIT

as specific as insulin itself

8401
RED CAP u40

8406
GREEN CAP u80

Postage
will be paid
by
Addressee

No
postage stamp
necessary
if mailed in the
United States

BUSINESS REPLY MAIL
First Class Permit No. 134, Fairview, N.J.

Becton-Dickinson and Company
Consumer Products Division
P.O. Box 183
Fairview, New Jersey 07022

Clip coupon on dotted line . . . fill out other side
send for physician's free samples

THE LEADING MANUFACTUR
OF INSULIN SYRING

B-D

BECTON, DICKINSON AND COMPA
RUTHERFORD, NEW JERSEY 07

color-coded caps and numbers—red for U40, green for U80

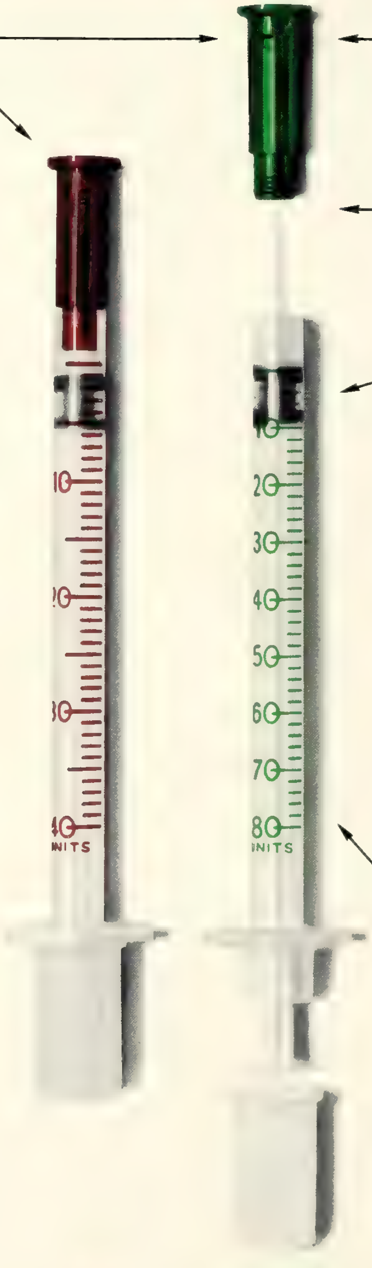
presterilized—consistently dependable, and sterility is assured until cap is opened

easy-to-hold, easy-to-handle—even for child diabetics with small hands or adults with stiff fingers

the sharpest needle your patient can buy—far sharper than any reusable needle

pocket-or-purse portable—sturdy from tip to top

integral cannula reduces air bubbles



single-scale
PLASTIPAK
insulin syringe
needle units
eliminate
the hazard
of reading
the wrong
scale

the first
insulin syringe
so low in cost
your patient
can use
a new one
every time

its single-scale—U40 or U80—minimizes the risk of measurement errors. Your patient *can't* read the wrong scale.

low cost—barely pennies higher than old-fashioned disposable needles without syringe . . . about as low as a cup of coffee

big numbers, wide spaces for easy reading

Supplied: in packages of 10—
PLASTIPAK syringe U-40 (red) or
PLASTIPAK syringe U-80 (green)
Prescription required in most states.

BECTON B-D
DICKINSON
Consumer Products Division
Becton, Dickinson and Company
Rutherford, New Jersey 07070

you can hang on for a few more minutes, Doctor
n sure I'll sneeze again.”

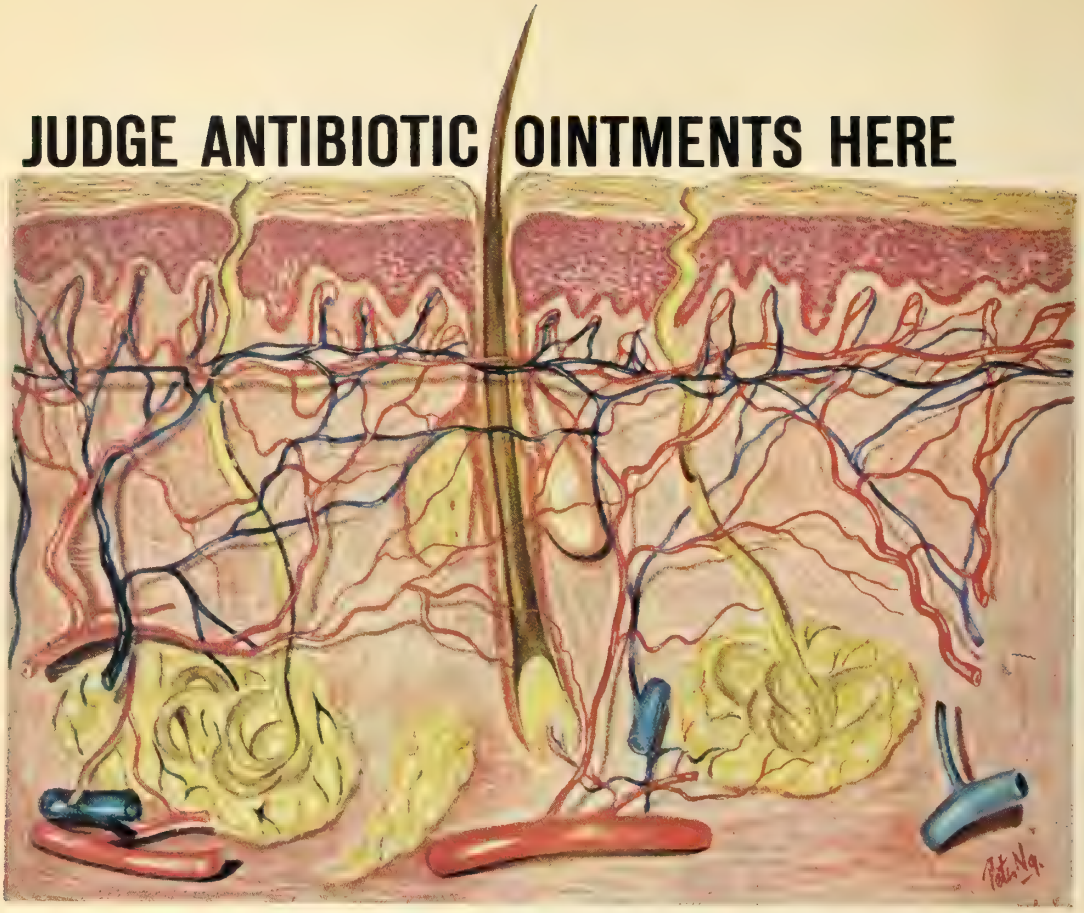
eeze. And sneeze some more. But with Novahis- LP, most patients get prompt and long-lasting rom the symptoms of allergies and colds. These uous-release tablets have a vasoconstrictor-anti- ine formulation that begins working in minutes, ontinues to provide relief for hours. Even when congestion is due to repeated allergic episodes, ovahistine LP tablets, morning and evening, let most patients breathe freely all day and all night. Use with caution in individuals with severe hypertension, diabetes mellitus, hyperthyroidism or urinary retention. Caution ambulatory patients that drowsiness may result.

Novahistine® LP decongestant

(Each tablet contains 25 mg. of phenylephrine hydrochloride and 4 mg. of chlorpheniramine maleate.)

DOW **THE DOW CHEMICAL COMPANY** Rx Pharmaceuticals Indianapolis

JUDGE ANTIBIOTIC OINTMENTS HERE



Results on skin are final proof of any topical antibiotic's effectiveness

No in vitro test can duplicate a clinical situation on living skin. 'Neosporin' (polymyxin B —bacitracin—neomycin) Ointment has consistently proven its effectiveness in thousands of cases of bacterial skin infection. The spectra of the three antibiotics overlap in such a way as to provide bactericidal action against most pathogenic bacteria likely to be found topically. Diffusion of the antibiotics from the special petrolatum base is rapid since they are insoluble in the petrolatum, but readily soluble in tissue fluids. The Ointment is bland and nonirritating.

Caution: As with other antibiotic preparations, prolonged use may result in overgrowth of nonsusceptible organisms and/or fungi. Appropriate measures should be taken if this occurs. Articles in the current medical literature indicate an increase in the prevalence of persons allergic to neomycin. The possibility of such a reaction should be borne in mind.

Contraindications: This product is contraindicated in those individuals who have shown hypersensitivity to any of its components.

Supplied: Tubes of 1 oz., ½ oz. with applicator tip, and ⅛ oz. with ophthalmic tip.

Complete literature available on request from Professional Services Dept. PML.

'NEOSPORIN'®
brand

POLYMYXIN B-BACITRACIN-NEOMYCIN
OINTMENT

BURROUGHS WELLCOME & CO. (U.S.A.) INC., Tuckahoe, N.Y.

Clinical Extension of a pure Smooth Muscle Relaxant

TROCINATE®

Brand THIPHENAMIL HCl

400 mg./100 mg. S/C tablets

Trocinate relaxes all smooth muscles. Its direct action (musculotropic) does not involve the autonomic nervous system and it is not mydriatic. It is metabolized by the body and eliminated in the urine as harmless degradation products. Trocinate has a remarkable history of freedom from side-effects.

When a pure direct-acting smooth muscle relaxant is indicated, Trocinate is the drug of choice.

DIARRHEA (functional) . . . *the first 400 mg. tablet usually relieves the discomfort of diarrhea so promptly that it ceases to be a bother.*

DIVERTICULITIS—MUCOUS COLITIS . . . *the accompanying discomforts can be relieved by this direct smooth muscle relaxant.*

BLADDER SPASM . . . *relaxation is immediate. One or two tablets condition the bladder for cystoscopy in one hour.*

SPASTIC URETER . . . *the specific relaxing effect of Trocinate on the spastic ureter has been proven by animal studies and affirmed clinically. (J. Urol. 73:487-93)*

PRESCRIBING INFORMATION

WARNING: Do not give in advanced kidney or liver disease. PRECAUTIONS: Trocinate relaxes all smooth muscles. Large dosage or prolonged usage may cause feeling of weakness or can theoretically precipitate gall-bladder colic, due to relaxing the vascular and duct systems. Caution should be observed in patients with urinary bladder obstruction. DOSAGE: 400 mg. May be repeated in 4 hours. After relief, lengthen the dose frequency. (see side note)

WILLIAM P. POYTHRESS & CO., INC.
RICHMOND, VIRGINIA 23217
Manufacturers of Ethical Pharmaceuticals

NOTE: *The high therapeutic index of Trocinate permits its administration in dosage sufficient to relieve smooth muscle spasm promptly. 400 mg. dosage usually creates a therapeutic blood level. In reducing dosage after relief, lengthening the time between dosage rather than lessening the recommended dose is preferable. The prompt direct action allows a consciousness of the first suggestion of return of symptom . . . a guide to dose spacing and to determining when treatment is complete. A prescription for twelve or sixteen 400 mg. tablets will usually correct spasm and leave a few tablets for a reserve.*

CHEESE FLAVORED
NET WT 6 OZ
CAUTION:
OVEREATING MAY BE HAZARDOUS TO YOUR HEALTH.

According to the Framingham Heart Study, the obese face:

86% greater risk of angina pectoris,
82% greater risk of diabetes,
71% greater risk of coronary heart disease.*

Obesity may also aggravate osteoarthritis, flat feet, intertriginous dermatitis, varicose veins, and ventral or diaphragmatic hernias.[1-3]

f you are considering weight reduction, consider **Preludin®**

phenmetrazine hydrochloride
Endurets®
prolonged-action tablets

Often effective

Controlled studies in a general patient population have shown that when Preludin is used with diet, the rate of weight loss exceeds that obtained by placebo and diet.

Long acting

Slow, even release of the active principle usually suppresses appetite continuously for about 12 hours.

Once-a-day dosage

One Endurets tablet after breakfast. It helps reduce weight and costs, conveniently.

For contraindications, warning, precautions, and adverse reactions, please see the full prescribing information.
It is summarized on this page.

Where there's no will there's a therapeutic way.

*Among persons 20% or more overweight as compared with median weight for persons of like height and sex.
1. Kannel, W.B., *et al.*: *Circulation* 35:734, 1967.
2. Thomas, H.E., Jr., *et al.*: *Med. Times* 95:1099, 1967.
3. Albrink, M.J., in: Beeson, P.B. & McDermott, W. (eds.): *Cecil-Loeb Textbook of Medicine*, ed. 12, Phila.: W.B. Saunders Co., 1967.

Preludin®
phenmetrazine hydrochloride
Preludin is indicated only as an anorexigenic agent in the treatment of obesity. It may be used in simple obesity and in obesity complicated by diabetes, moderate hypertension (see Precautions), or pregnancy (see Warning).
Contraindications: Severe coronary artery disease, hyperthyroidism, severe hypertension, nervous instability, and agitated prepsychotic states. Do not use with other CNS stimulants, including MAO inhibitors.
Warning: Do not use during the first trimester of pregnancy unless potential benefits outweigh possible risks. There have been clinical reports of congenital malformation, but causal relationship has not been proved. Animal teratogenic studies have been inconclusive.
Precautions: Use with caution in moderate hypertension and cardiac decompensation. Cases involving abuse of or dependence on phenmetrazine hydrochloride have been reported. In general, these cases were characterized by excessive consumption of the drug for its central stimulant effect, and have resulted in a psychotic illness manifested by restlessness, mood or behavior changes, hallucinations or delusions. Do not exceed recommended dosage.
Adverse Reactions: Dryness or unpleasant taste in the mouth, urticaria, overstimulation, insomnia, urinary frequency or nocturia, dizziness, nausea, or headache.
Dosage: One 25 mg. tablet b.i.d. or t.i.d. Or one 75 mg. Endurets tablet a day, taken by midmorning.
Availability: Pink, square, scored tablets of 25 mg. for b.i.d. or t.i.d. administration, in bottles of 100 and 1000.
Pink, round Endurets® prolonged-action tablets of 75 mg. for once-a-day administration, in bottles of 100 and 1000.
(B)R3-46-560-B
For complete details, please see full prescribing information.

Under license from
Boehringer Ingelheim G.m.b.H.

Geigy Pharmaceuticals
Division of
Geigy Chemical Corporation
Ardsley, New York 10502

PR-7169

4-H Projects May Soon Include Smoking, Health Careers

Michigan's 4-H Club leaders will have the opportunity soon to include projects on health careers and smoking and health in their club meetings, due to the efforts of the Michigan Health Council and the State 4-H Extension Office at Michigan State University.

Extension office personnel will begin revision this summer of the 110-page 4-H leaders guidebook. The new guidebook will include lists of publications for leaders and club members about smoking and health careers, lesson plans for various age levels and projects in smoking education and health careers appropriate for youth at various ages to carry out.

The materials eventually will be distributed to about 15,000 adult 4-H leaders, who direct the activities of about 75,000 4-H Club members in Michigan.

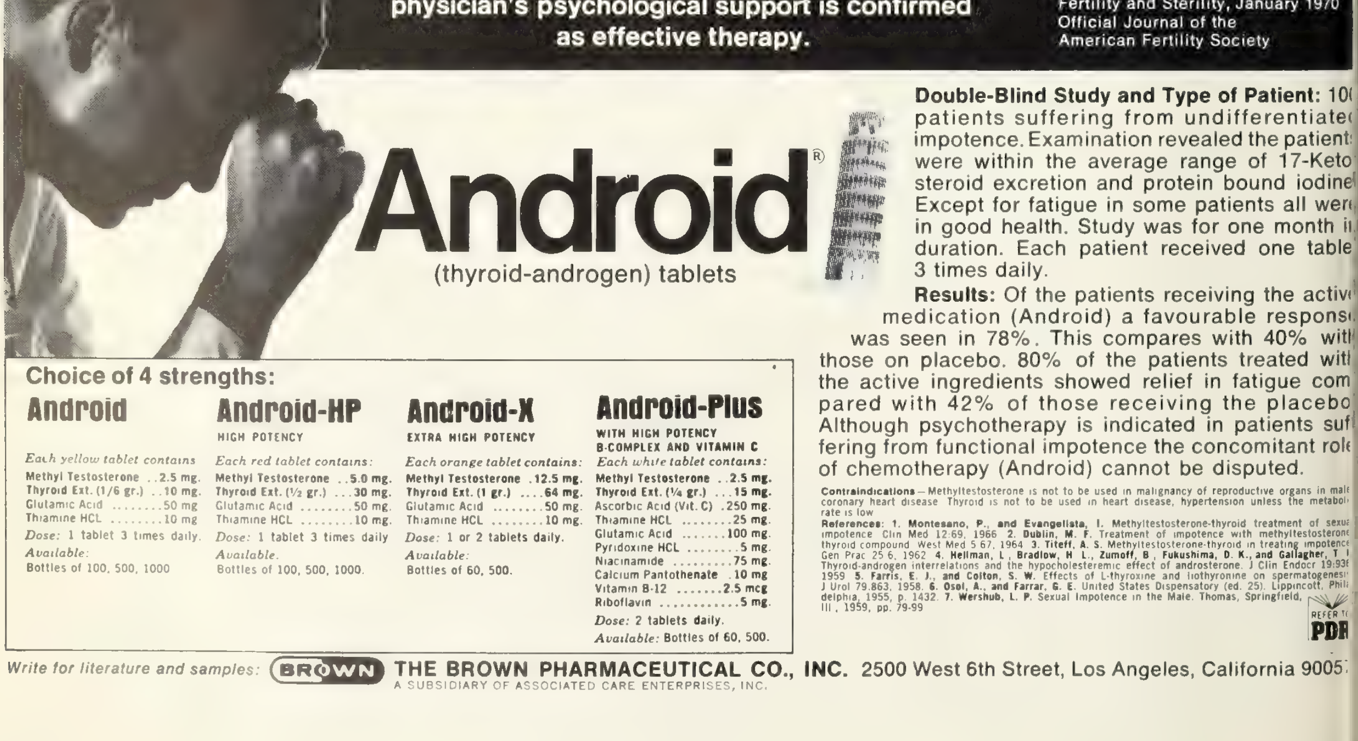
Health Council personnel John Hyde, coordinator, MHC Health Manpower Programs, and William Bresler, coordinator of MHC Smoking and Health Programs, worked with Carroll Wamhoff, Ph.D., program leader, 4-H — Youth Programs, in developing the new sections.

In addition Health Council representatives hope to speak with large groups of 4-H leaders and are exploring possibilities of developing similar programs with the state Boy Scout and Girl Scout programs.

U-M Offers New Residency in Preventive Medicine

The School of Public Health at the University of Michigan has organized a program of residency training in preventive medicine. Designed to prepare physicians for administrative, research and teaching careers and approved by the American Board of Preventive Medicine, this three-year program permits residents to specialize in one of the following areas: epidemiology, industrial medicine, maternal and child health, medical care organization, population planning and public health administration.

Physicians with the M.P.H. or its equivalent may be admitted directly into the second year of residency training. Further details may be obtained from Myron E. Wegman, M.D., dean of the University of Michigan School of Public Health.



The treatment of

impotence

in the American male is complex.
The concept of chemotherapy plus the physician's psychological support is confirmed as effective therapy.

NEW CLINICAL STUDY

The Treatment of Impotence with Methyltestosterone Thyroid (100 patients — Double Blind Study)
T. Jakobovits
Fertility and Sterility, January 1970
Official Journal of the American Fertility Society

Android®
(thyroid-androgen) tablets

Double-Blind Study and Type of Patient: 10 patients suffering from undifferentiate impotence. Examination revealed the patient were within the average range of 17-Keto steroid excretion and protein bound iodine Except for fatigue in some patients all were in good health. Study was for one month in duration. Each patient received one table 3 times daily.

Results: Of the patients receiving the activ medication (Android) a favourable respons was seen in 78%. This compares with 40% wit those on placebo. 80% of the patients treated wit the active ingredients showed relief in fatigue compared with 42% of those receiving the placebo Although psychotherapy is indicated in patients suffering from functional impotence the concomitant rol of chemotherapy (Android) cannot be disputed.

Contraindications — Methyltestosterone is not to be used in malignancy of reproductive organs in mal coronary heart disease Thyroid is not to be used in heart disease, hypertension unless the metabol rate is low

References: 1. **Montesano, P., and Evangelista, I.** Methyltestosterone-thyroid treatment of sexu impotence Clin Med 12:69, 1966 2. **Dublin, M. F.** Treatment of impotence with methyltestosteron thyroid compound West Med 5 67, 1964 3. **Titeff, A. S.** Methyltestosterone-thyroid in treating impotenc Gen Prac 25 6, 1962 4. **Hellman, L, Bradlow, H L., Zumoff, B, Fukushima, D. K., and Gallagher, T** Thyroid-androgen interrelations and the hypocholesteremic effect of androsterone. J Clin Endocr 19:93 1959 5. **Farris, E. J., and Colton, S. W.** Effects of L-thyroxine and liothyronine on spermatogenes J Urol 79.863, 1958. 6. **Osol, A., and Farrar, G. E.** United States Dispensatory (ed. 25). Lippincott, Phil delphia, 1955, p. 1432. 7. **Wershub, L. P.** Sexual Impotence in the Male. Thomas, Springfield, Ill., 1959, pp. 79-99

REFER T
PDR

Choice of 4 strengths:

Android

Each yellow tablet contains
Methyl Testosterone ..2.5 mg.
Thyroid Ext. (1/6 gr.) ..10 mg.
Glutamic Acid ....50 mg
Thiamine HCL ....10 mg
Dose: 1 tablet 3 times daily.
Available:
Bottles of 100, 500, 1000

Android-HP
HIGH POTENCY

Each red tablet contains:
Methyl Testosterone ..5.0 mg.
Thyroid Ext. (½ gr.) ...30 mg.
Glutamic Acid ....50 mg.
Thiamine HCL ....10 mg.
Dose: 1 tablet 3 times daily
Available.
Bottles of 100, 500, 1000.

Android-X
EXTRA HIGH POTENCY

Each orange tablet contains:
Methyl Testosterone .12.5 mg.
Thyroid Ext. (1 gr.) ....64 mg.
Glutamic Acid ....50 mg.
Thiamine HCL ....10 mg.
Dose: 1 or 2 tablets daily.
Available:
Bottles of 60, 500.

Android-Plus
WITH HIGH POTENCY B-COMPLEX AND VITAMIN C

Each white tablet contains:
Methyl Testosterone ..2.5 mg.
Thyroid Ext. (¼ gr.) ...15 mg.
Ascorbic Acid (Vit. C) .250 mg.
Thiamine HCL ....25 mg.
Glutamic Acid ....100 mg.
Pyridoxine HCL ....5 mg.
Niacinamide ....75 mg.
Calcium Pantothenate .10 mg
Vitamin B-12 ....2.5 mcg
Riboflavin ....5 mg.
Dose: 2 tablets daily.
Available: Bottles of 60, 500.

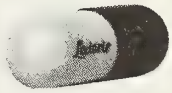
Write for literature and samples: BROWN THE BROWN PHARMACEUTICAL CO., INC. 2500 West 6th Street, Los Angeles, California 9005
A SUBSIDIARY OF ASSOCIATED CARE ENTERPRISES, INC.

Doctor, after all we've been through together...

abscess
acne
amebiasis
anthrax
bacillary dysentery
bartonellosis
bronchitis
bronchopulmonary infection
brucellosis
chancroid
diphtheria
endocarditis
genitourinary infections
gonorrhea
granuloma inguinale
listeriosis
lymphogranuloma
mixed bacterial infection
osteomyelitis
otitis
pertussis
pharyngitis
pneumonia
psittacosis
pyelonephritis
Rocky Mountain spotted fever
scarlet fever
septicemias
sinusitis
soft tissue infection
tonsillitis
tularemia
typhus fever
urethritis

...don't you think it's time we were on a first-name basis?

call me "Achro® V"



Every pharmacist knows ACHRO® V stands for ACHROMYCIN® V

ontraindications: Hypersensitivity to tracycline.
'arning: In renal impairment, since ver toxicity is possible, lower doses e indicated; during prolonged therapy onsider serum level determinations. otodynamic reaction to sunlight may cur in hypersensitive persons. otosensitive individuals should oid exposure; discontinue treatment skin discomfort occurs.
ecautions: Nonsusceptible organisms may overgrow; treat superinfection appropriately. Tetracycline may form a stable calcium complex in bone-forming tissue and may cause dental staining during tooth development (last half of pregnancy, neonatal period, infancy, early childhood).
Adverse Reactions: *Gastrointestinal*—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. *Skin*—maculopapular and erythematous rashes; exfoliative dermatitis; photosensitivity; onycholysis, nail discoloration. *Kidney*—dose-related rise in BUN. *Hypersensitivity reactions*—urticaria, angioneurotic edema, anaphylaxis. *Intracranial*—bulging fontanels in young infants. *Teeth*—yellow-brown staining; enamel hypoplasia. *Blood*—anemia, thrombocytopenic purpura, neutropenia, eosinophilia. *Liver*—cholestasis at high dosage. Upon adverse reaction, stop medication and treat appropriately.

Achromycin® V
Tetracycline

Lederle LEDERLE LABORATORIES • A Division of American Cyanamid Company, Pearl River, New York 10965

484-9

in memoriam

George H. Boyce, M.D.
Iron Mountain

George H. Boyce, M.D., Iron Mountain specialist for 60 years, died April 10 at the age of 90.

Doctor Boyce was affiliated with Iron Mountain Memorial Hospital and was a past president of the Dickinson-Iron County Medical Society. His specialty was ophthalmology, otology, laryngology and rhinology.

He was a graduate and a fellow of the Toronto Medical School.

Arthur C. Henthorn, M.D.
St. Johns

Arthur C. Henthorn, M.D., St. Johns' oldest physician, died May 15 at the age of 81.

Doctor Henthorn, who was a St. Johns surgeon since 1924, had just retired in April. He was former chief of staff and director of surgery at Clinton Memorial Hospital.

Doctor Henthorn was also a former Chesapeake and Ohio Railway surgeon, former P.A. surgeon with the U.S. Public Health Service and former director of surgery for the Veterans Bureau at St. Mary's and Butterworth Hospitals in Grand Rapids.

He was a past president of the Clinton County Medical Society and was graduated from the University of Louisville School of Medicine.

Harry A. Kashtan, M.D.
Detroit

Harry Aaron Kashtan, M.D., a member of the staffs of Harper and Sinai Hospitals in Detroit, died April 24 at the age of 51.

Doctor Kashtan, a graduate of Wayne State University School of Medicine, was an associate of the American College of Physicians and a member of the Michigan Heart, Rheumatism and Diabetes Societies.

He was a clinical instructor at Wayne State University and was an internist.

Bruce C. Lockwood, M.D.
Southfield

Bruce C. Lockwood, M.D., former head of internal medicine, Harper Hospital, Detroit, died April 21 in Fort Lauderdale. A retired internist, he made his home in Southfield. He was 80.

Doctor Lockwood was a graduate of the University of Michigan College of Medicine and was former secretary of the Wayne County Medical Society.

Ralph Marinelli, M.D.
Bloomfield Hills

Ralph Marinelli, M.D., a Detroit-area obstetrician and gynecologist for 20 years, died April 11 at the age of 48.

A graduate of the University of Bologna, Italy, Doctor Marinelli was affiliated with William Beaumont Hospital in Royal Oak and Ardmore General Hospital in Ferndale.

J. Stanley Schultz, M.D.
Flint

J. Stanley Schultz, M.D., chief of the medical staff of Winchester Hospital, Flint, died May 10 at the age of 57.

Doctor Schultz, who was a Flint teacher from 1936-42, was former chief of general practice at Hurley Hospital, and former chief of staff of McLaren General Hospital.

A general practitioner, he was a member of the American Association of General Practitioners and the American Geriatric Society and was graduated from Wayne State University School of Medicine. He was medical coordinator for the local Visiting Nurse Association.

Kellogg Foundation Gives $1 Million To MSU Med College

The W. K. Kellogg Foundation of Battle Creek has granted $1 million to help Michigan State University expand its College of Human Medicine into a full degree program. The Kellogg grant, to be spread over five years, was the first outside support for Michigan State's medical school since the legislature authorized planning for the third and fourth years of medical education at MSU.

The Kellogg grant will be used to hire additional faculty members who will conduct the planning and then continue on the teaching staff of the expanded school.

Come see a love story.

The year was 1948.

In a rented building outside of Stuttgart, Germany, an old man, his son and a dozen workers began building an automobile.

After a lifetime of designing cars for other people, this one would be the first to bear his name.

Three years later Professor Ferdinand Porsche was dead. But he'd left behind, in his son, the determination to build great cars.

Today, Porsches are still made in Stuttgart. And Porsches are still made by Porsches.

Ferry, the son who worked on the 1948 car with his father, works on the 1970 cars with his sons.

Butzi, who designs them. Peter, who's in charge of production. And Wolfgang, who'll learn the business from the bottom up.

The generations have changed. And so have the cars. But one thing has stayed the same.

The love that went into the first Porsche 21 years ago goes into every Porsche that's made today.

And we have one that was made for you.

PORSCHE®

Prestige Automobiles, Inc.
2955 S. Division Ave., Grand Rapids

Phil Gordon's, Inc.
2924 E. Grand River Ave., Lansing

Wood Imports, Inc.
15415 Gratiot Ave., Detroit

Tom Sullivan Porsche Audi, Co.
499 S. Hunter Blvd., Birmingham

Classified Advertising

$5.00 per insertion of 50 words or less, with an additional 10 cents per word in excess of 50.

ANN ARBOR - YPSILANTI AREA. Three year AMA approved, university affiliated psych. residency offering comprehensive MH services to SE Michigan. Teaching faculty and supervisors include U. of M. faculty, private psychiatrists and analysts, as well as hospital staff. Resident's time divided approx. equally between didactic seminars (including supervision) and clinical experience. First year ADM & Intensive Treatment units; second and third year assigned Community Psych. and/or OPC and/or Children's Unit. Additional experience in psychosomatic medicine, Univ. Mental Hygiene Clinic, and neurology. 3-year: $10,669 to $12,131. 5-year: $12,152 to $21,944. $15,000 NIMH grants available eligible physicians in practice 4+ years. Contact: J. Tiziani, M.D., Ypsilanti State Hospital, Ypsilanti, Michigan 48197.

INTERNIST needed for established multi-specialty group in Detroit. Excellent professional relationship. Reply: Box 14, 120 W. Saginaw Street, East Lansing, Michigan 48823.

GENERAL PRACTITIONER — SURGEON: Community in southern, central Michigan Resort area has need for several doctors. Two doctors recently retired. New, modern, all-accredited hospital. Good hunting, fishing and lake area. Large, new artificial lake now under construction. For additional information call: (313) 448-2371 or write L. E. Weight, Secretary, Board of Trustees, Thorn Hospital, Hudson, Michigan 49247.

PSYCHIATRISTS: Avoid pollution — enjoy fresh air, clean water, less people in summer-winter vacationland near Interlochen Arts Academy. Small town peace and quiet. Big City culture and salaries. Progressive psychiatric hospital, JCAH approved, 3 year psychiatric residency program. Salaries to $32,364 if you qualify, excellent fringes, housing available. Contact M. Duane Sommerness, M.D., Traverse City State Hospital, Traverse City, Michigan 49684.

RADIOLOGIST wanted for association in full time hospital practice. Become first associate. Hospital actively expanding. Excellent financial arrangement. Contact: G. R. Hassett, M.D., St. Mary Hospital, 36475 W. Five Mile Road, Livonia, Michigan 48154 or Phone (313) GA 7-4819 Ext. 228.

FAMILY PRACTICE PHYSICIANS — Board of Trustees of St. Mary's Hospital in Marquette invites family practice physicians to practice in Michigan's upper peninsula. This community has two hospitals, excellent schools, churches and year-round sports activities. This hospital is a 126 bed modern, well equipped, JCAH accredited general hospital including psychiatric and rehabilitation units in which to practice professional skills. Interested physicians may contact: Archie S. Narotzky, M.D., Chief of Staff, St. Mary's Hospital, Marquette, Michigan 49855.

WANTED: Internist to join two man partnership in Michigan's upper thumb area. Excellent recreation and educational facilities are available. Write to: K. B. Herrington, M.D. or Kenneth S. Kube, M.D., 669 South Van Dyke, Bad Axe, Michigan. May call collect: (517) 269-6453.

1248 Sq. Ft. in new medical suite, carpeted waiting room and halls, four treatment rooms, one with an emergency entrance, laboratory, two lavatories, business and reception offices, panelled private office. 1628 Merriman in Westland. Call 728-1730 or 271-6696 area (313).

EXTREMELY BUSY two man group needs OB man, who is willing to do some general practice, or a GP who particularly wants to do OB. New modern 80 bed hospital with CCU unit. Small town in Northern Michigan, serving an area of about 12,000 people. Office space available, and financial arrangements entirely open to discussion. P.C. possible. Write Box 12, 120 West Saginaw Street, East Lansing, Michigan 48823, or phone (517) 846-6122.

GENERAL PRACTICE AVAILABLE: Urgent, Excellent select clientele in solo general practice established eleven years. Open staff hospital ½ mile distance. Will introduce to practice. 1600 Sq. Ft. solo office with parking available to rent or lease. Terms open. Contact Box 13, 120 West Saginaw St., East Lansing, Michigan, 48823 or Phone: (313) 468-6302, Mt. Clemens, Michigan.

PSYCHIATRIC RESIDENCIES: We offer nothing but excellent psychiatric training in a stimulating, well-organized program located in a culturally advantaged community. Approved psychiatric training. Traverse City State Hospital, Michigan Department of Mental Health. Three and five year programs. Salary, Three Year Program: $11,359; $11,922; $12,925. Five Year Program: $12,945; $14,950; $17,393; $23,198; $24,409. NIMH-GP stipends available. Located in Michigan's serene, scenic recreation area on Grand Traverse Bay. Contact Dr. Paul E. Kauffman, Director of Training, Traverse City State Hospital, Traverse City, Michigan 49684. An equal opportunity employer.

FOR SALE: Completely furnished office of General Practitioner who is leaving practice on August 1, 1970. This busy town can accommodate a general surgeon or general practitioner. Price will be based on fair appraisal. Write: John K. Hickman, M.D., 108 W. Division Street, Dowagiac, Michigan.

WANTED: Internist to join 2 man partnership in Michigan's upper Thumb area. Excellent recreation and educational facilities are available. Write to K. B. Herrington, M.D., or Kenneth S. Kube, M.D., 669 South Van Dyke, Bad Axe, Michigan 48413. May call collect: (517) 269-6453.

GENERAL PRACTITIONERS: Have you had your fill of the "Rat Race"? Are you tired of filling out forms such as for Medicare, Medicaid, etc.? If so, come with us. We have a campus which is going to grow to 20,000 students. We will be in a new Health Service building in 1972. We offer a competitive salary, excellent fringe benefits, and the opportunity to improve yourself. Contact: Harold J. Reese, M.D., Director, Student Health Service, Central Michigan University, Mt. Pleasant, Michigan 48858. Phone (517) 774-3058.

FULL TIME PHYSICIAN for automotive plant employing 6,800. Good salary, excellent benefits, regular hours, fine working conditions. We are an equal opportunity employer. Reply to Box #15, 120 West Saginaw Street, East Lansing, Michigan 48823.

WANTED: Physician to join private group limited to the practice of industrial medicine. Top remuneration, profit sharing, pension plan, insurance program, liberal vacation program. REGULAR HOURS. Address replies to: R. R. Silver, M.D., 60 W. Hancock, Detroit, Michigan 48201 or call R. R. Silver, M.D., or D. Jacknow, M.D., at (313) TE 1-3130 or (313) 756-5800.

FOR LEASE: In new medical, dental building. Two suites available, or will combine for a total of 2200 sq. ft. Also, 2500 sq. ft. of lower level area available, ideal for dental or other type laboratory. Will design street level and lower level to your specifications. Located in the City of Grandville, Michigan. Easy access to shopping centers, expressways, and housing. Lease includes paved offstreet parking, all utilities, and all services. Reply to Prairie Street Realty Corp., 2700 – 28th Street, S.W., Grand Rapids, Michigan or phone (616) 538-9000.

RADIOLOGIST, full-time, for accredited hospital in Detroit. Excellent remuneration. Reply to Box 16, 120 West Saginaw Street, East Lansing, Michigan 48823.

ESTABLISHED FAMILY PRACTICE available January 1, 1971. Completely furnished office. Leaving for residency. A. G. Craymer, M.D., 420 N. Rath Avenue, Ludington, Michigan 49431. Phone (616) VI 5-6352.

FOR SALE: Picker X-ray with Fluoroscopic, developer, etc., in excellent condition. Reasonable or for tax credit. Rex A. Wilcox, M.D., 525 N. State Street, Alma, Michigan 48801. Call collect (517) 463-2200.

Ulcer Re-lief!

Dicarbosil®

ANTACID

Your ulcer patients and others will respond favorably to it. Specify DICARBOSIL 144's—144 tablets in 12 rolls.

ARCH LABORATORIES
319 South Fourth Street, St. Louis, Missouri 63102

Index to Advertisers

Advertisers in *Michigan Medicine* are friends of the profession. By accepting their advertising we show confidence in them, their services and products. They help make the journal a quality publication. Please familiarize yourself with their services and products and let them know that you see their advertising in *Michigan Medicine*.

Arch Laboratories 629
Becton, Dickinson 617, 618
Breon Laboratories 557
Brighton Hospital 607
Bristol Laboratories 564, 565
Brown Pharmaceuticals 624
Burroughs-Wellcome & Co. 620
Campbell Soup Co. 589
Classified Ads 628, 629
Conal Pharmaceuticals 592
Dow Chemical Co. 619
Geigy Pharmaceuticals 622, 623
Hynson, Westcott and Dunning, Inc. 553
Import Motors 627
Lederle Laboratories 554, 597, 625
Lilly, Eli and Co. 568
Medical Protective Co. 610
Mercywood Hospital 598
National Drug Co. .... Cover II, 593, 594,
615, 616
Plainwell Sanitarium 595
Poythress, Wm. P. 621
Professional Management 602
Roche Laboratories .... Cover IV
Schering Corp. 603, 604, 605, 606
Searle, G. D., and Co. 590, 591
Stratton, Ben P., Ins. .... Cover II
Stuart Pharmaceuticals, Division of
Atlas Chemical Industries, Inc. 567
Walker Corp. and Co. 608, 609
Wyeth Laboratories 561, 562

noted and quoted

BY HERB AUER, EXECUTIVE EDITOR

A recent editorial in the *Pontiac Press* quoted MSMS President Robert J. Mason, M.D., about the shortage of physicians and the need to expand first-year enrollment at the three Michigan medical schools to 500-600 students.

The editorial concluded:

"It is clear, however, that if Michigan — one of the fastest growing states in the Union — is to keep abreast of the spiraling demand for doctors, the capacity of its medical schools must be substantially increased, and the archaic law that penalizes doctors from other states realistically modified."

* * *

The national Blue Shield-Blue Cross organization is running an advertisement in some magazine which personally appeals to me as a fine approach. Perhaps you have not seen it. It reads like this:

"The old against the young. The blacks against the whites. The rich against the poor.

"That's about all there is to America today, if you believe everything you see on television and read in the papers.

"Before you know it, you begin to feel that you have nothing in common with a lot of Americans.

"You begin to imagine that they are out to have it their way, even if it means destroying the country.

"By burning it down, just to show how angry they are.

"Or by abolishing our fundamental individual freedoms, just to keep things peaceful and quiet.

"Blue Cross/Blue Shield is convinced that the biggest threat to the health of our country is the growing feeling of fear, anger, and loneliness among our people.

"You live with that feeling every day, and your mind and body might not be able to take it much longer. Then you'd start to have some strange symptoms:

"Headaches.

"Ulcers.

"Even nightmares.

"One day you'd start to imagine that those 'other people' don't really belong in America at all.

"And they could easily begin to feel that you don't belong here, either.

"That kind of thinking can only lead to a showdown. One that nobody can win.

"That's why we want to remind you of two things that are terribly easy to forget these days:

"You're not the only American who'd be sad to see his country fall apart.

"You're not the only American who will do what's necessary to keep his country together.

"Every other American will, too.

"It's the only country he's got.

"And he knows it.

"WE NEED EACH OTHER.

"YOU CAN ALMOST HEAR THE COUNTRY CRYING."

* * *

"During the 70's most association members will find it prudent to invest from two to five times more in association dues than they are now investing. This increased income will make it possible for associations to have the professional staff needed to provide the extra services for its members."

So wrote R. L. Skinner, of Des Moines, member of the board of directors of the American Society for Association Executives, in the May issue of *Association Management.*

* * *

It happened! A book publisher recently ran an ad for a proofreader. In part, the ad indicated the firm was looking for "experienced person; strong on grammar and spellig, meticuliouss and well-organized."

* * *

A magazine advertisement quotes a research director of a pharmaceutical company as saying:

"You're part of the establishment, my kids tell me. Your company makes profits from sick people while you sit in the laboratory doing research of doubtful value.'

The ad, developed by the Pharmaceutical Manufacturers Association, goes on to report that "o 528 new drugs originated in the USA from 1940 to 1968, about 90 per cent came from Pharmaceutical industry labs." The PMA message also points out that pharmaceutical firms "use their own income from sales to finance more than half a billion dollars in research and development each year."

* * *

While America's "archaic" medical care system chugs along, the "model" system in Great Britain soaks taxpayers $2,400,000 annually for free wigs that cost $78.20 each according to the Ohio State Medical Association *OSMAGRAM* Average American per capita expenditure for all out-of-hospita prescriptions in 1967 was $16.58

* * *

". . . the big lie, loudly proclaimed can become truth."

—Gardner Ackley
U-M Economic Professo

michigan medicine

U. C. SAN FRANCISCO
MEDICAL CENTER LIBRARY
AUG 27 1970

matous Disease of Childhood
he Health Care System
nd Aid to Fayette, Miss.

Block Out Your Calendar Now

Sept. 20-22	MSMS House of Delegates
Sept. 22-24	Woman's Auxiliary to MSMS
Sept. 23-24	MSMS Annual Scientific Session

Michigan State Medical Society
August 1970, Volume 69, Number 15

NOW... a new sponsored insurance plan

THE ULTIMATE IN INSURANCE PROTECTION

MSMS PERSONAL PRESTIGE POLICY

**DESIGNED FOR AND SPONSORED BY THE
MICHIGAN STATE MEDICAL SOCIETY**

Remember *Yesterday's* Liability Limits Invite Financial Disaster *Today.* The Answer to this Dilemma is Provided in This Comprehensive Policy.

Here are some of the things it does:

★ PROVIDES LIABILITY COVERAGE ABOVE BASIC INSURANCE IN AMOUNTS OF $1,000,000 TO $5,000,000

★ APPLIES TO ALL EXPOSURES SUCH AS PROFESSIONAL LIABILITY, AUTOMOBILE, OFFICE PREMISES, RESIDENCE, BOATS AND AIRCRAFT

AND ALSO PROVIDES A MAJOR MEDICAL SECTION UP TO $25,000 TO SUPPLEMENT YOUR BASIC HEALTH PLAN

CALL US COLLECT: 517 484-2578 TO LEARN FIRST HAND HOW WE CAN PROVIDE YOU WITH THIS NEEDED COVERAGE AT A REASONABLE COST.

bps **BEN P. STRATTON AGENCY, INC.**
ESTABLISHED IN 1937

19400 WEST TEN MILE ROAD
SOUTHFIELD, MICHIGAN 48075
357-5083

107 N. BUTLER BLVD.
LANSING, MICHIGAN 48903
(517) 484-2578

Breaking News: Deadline July 9
July 1970, Volume 69, Number 14
Michigan State Medical Society

U. C. SAN FRANCISCO
MEDICAL CENTER LIBRAR
JUL 31 1970

michigan medicine

Is Your Field Virology, Cardiology, Nephrology?

Learn The New Developments of 10 Specialties At 1970 MSMS Annual Session Sept. 20-24

One of the most popular portions of recent MSMS Annual Session meetings has been the series of talks entitled "What's New in the Practice Of . . ."

During the 1970 MSMS Annual Session, the new developments in several specialties will be discussed starting at 9 a.m. Thursday, Sept. 24, in the Ballroom Annex of the Sheraton-Cadillac Hotel, Detroit.

During the 10 segments of the morning program, specialists in virology, antibiotics, liver disease, psychiatry, nuclear medicine, cardiology, anesthesiology, human genetics, nephrology and dermatology will report on the latest research and treatments in their specialties.

Specialists who will lead each of the sessions will include A. Martin Lerner, M.D., professor of medicine, WSU, virology; F. Robert Fekety, M.D., associate professor and head of the Section on Infectious Diseases, U-M Medical School, antibiotics; William S. Haubrich, M.D., Division of Gastroenterology, Henry Ford Hospital, liver disease, and James E. Baker, M.D., director, Battle Creek VA Hospital, psychiatry.

Others will be Howie Dworkin, M.D., head of the Department of Nuclear Medicine, Beaumont Hospital, nuclear medicine; Irwin J. Schatz, M.D., associate professor of Medicine, WSU School of Medicine, cardiology; Paul R. Dumke, M.D., Detroit, anesthesiology, and Donald L. Rucknagel, M.D., associate professor, Department of Human Genetics, U-M Medical Center, human genetics.

Other guest speakers will talk about innovations in the fields of nephrology and dermatology.

Two Candidates Named As Seeking Deanship Of MSU DO School

A neurologist from the National Institutes of Health and the dean of the Michigan Osteopathic School appear to be leading contenders for appointment as dean of the College of Osteopathic Medicine at Michigan State University.

An MSU official confirmed July 7 that Murray Goldstein, D.O. of Bethesda, Md., and Myron S. Magen, D.O., dean of the Michigan Osteopathic School at Pontiac, were among the four candidates. He declined to name the other two.

The MSU official confirmed reports that Doctor Goldstein had been on the MSU campus twice for interviews. Doctor Magen is "frequently on campus," he said.

SHERATON CADILLAC

Recently the Adult Education Association of Michigan presented its top award for "Creativity in Adult Education" to MSMS, the Wayne County Medical Society and the **Detroit News** for the series of public forums sponsored by the three groups in Detroit. Receiving the award from Wesley Joliffe, third from left, are Herbert A. Auer, representing MSMS; Jean Pearson, **Detroit News** science editor, and Sidney E. Chapin, M.D., far right, PR chairman for WCMS. Among the runner-up award recipients were U of M, MSU and other educational and civic groups.

Report of Michigan Delegation's Recommendations To AMA House of Delegates at Annual Meeting

The Michigan delegation to the AMA Annual Meeting June 21-25 in Chicago led an active part in the House of Delegates meeting at the Palmer House.

They and their chairman, Donald N. Sweeny, Jr., M.D., Detroit, were also pleased to note that the new AMA president, Walter C. Bornemeier, M.D., formerly practiced in Coldwater, Mich.

The following is an account of resolutions introduced by the Michigan delegation and acted upon by the AMA House of Delegates.

Resolution No. 20

Subject: School Health Committees

Resolved: That the AMA encourage the state medical associations to request state departments of education and school districts to appoint such school health committees, and be it further

Resolved: That local boards of education appoint at least one physician to such committees because doctors of medicine have valuable contributions to make to such committees.

The reference committee acted favorably on this and recommended the insertion of the words "be urged to" between the words "education" and "appoint." The House approved the amended resolution.

Resolution No. 21

Subject: Advertising Regulations for Proprietary Drugs

Resolved: That so-called proprietary or nonprescription drugs be subject to the same advertising regulations pertaining to ethical or prescription drugs in their advertising in the usual press and periodical media; and be it further

Resolved: That literature pertaining to ingredients, dosage, side effects and adverse reactions, be included in the packaging and dispensing of such drugs.

The reference committee agreed with the intent of Resolution No. 21 but noted prescription drug advertising regulations would not solve the problems noted in the resolution. Accordingly, they recommended the following substitute resolution:

Resolved: That the AMA express the concern of the medical profession that consumer protection be assured through more adequate surveillance of proprietary drug advertisements by private organizations and more effective cooperation in enforcement of applicable regulations by responsible governmental agencies. The House adopted the substitute resolution.

Resolution No. 96

Subject: Proposed AMA Dues Increase

Resolved: That the question of an increase in dues be postponed until the members of the House of Delegates are better informed; and be it further

Resolved: That all members of the House of Delegates be furnished a complete, detailed and understandable financial breakdown of our cost figures and projected future budgeting costs for their study before any action is taken; and be it further

Resolved: That any action on dues increase be deferred until the 1970 clinical session.

(By way of explanation, the Board of Trustees had recommended to the House of Delegates a dues increase of $80 per year. In their instructions to the House, the House could not change the figure of $80 per year but could only accept or reject this figure. California, therefore, proposed Resolution No. 95, Subject: Bylaws change, annual dues. This was referred to the Reference Committee on Amendments to Constitution and Bylaws, chaired by Donald N. Sweeny, Jr., M.D., Detroit. Resolution No. 95 read: Resolved, that chapter three, section one, paragraph A of the bylaws of this association be amended to read: (A) How prescribed. Annual dues for any year shall be prescribed in an amount fixed and determined by the House of Delegates. The Board of Trustees may submit recommendations to the House on fiscal needs of the association and level of the dues. Dues fixed by the House shall remain in effect until changed. This was adopted and the bylaws were therefore changed.)

The reference committee considering Resolution No. 96 recommended that it not be adopted. The House accepted the recommendation of the reference committee and the resolution was lost.

The reference committee then recommended that report B — pertaining to dues increase — of the Board of Trustees be filed for information, that a dues increase in the amount of $40 be adopted at this present convention and that full and explicit information supporting the need for future dues increases be promptly distributed by the Board of Trustees to constituent state medical associations. This was adopted by the House of Delegates.

The reference committee further recommended that the constituent state medical associations be vigorously encouraged to disseminate to their individual members the information supplied by the Board of Trustees supporting the need for future dues increases and to use every reasonable means to persuade the individual members to accept the future dues increases justified by such information. The House likewise adopted this recommendation.

Recommendation No. 97

Subject. Reaffirmation of AMA Policy on Abortions

Resolved: That this House of Delegates reaffirm the action of the 1967 House of Delegates regarding abortion. This resolution was lost. A substitute resolution was introduced by Michigan on the floor of the House with the same reaffirmation, with slight changes. This likewise was lost.

Eleven Medical Students Spending Summer At Michigan Hospitals

Eleven medical students from Michigan universities are currently engaged in summer preceptorships in Michigan hospitals under a pilot program sponsored by the Student American Medical Association, in cooperation with MSMS and the Michigan Hospital Association.

The SAMA-MECO (Medical Education and Community Orientation) project, approved by the MSMS House of Delegates in their April 22 meeting, was initiated last year in Illinois. It is being expanded this summer to seven more states, with Michigan the second to be organized.

The students and the hospitals in which they are gaining clinical experience are Randall Riggs, Wayne State University, Cottage Hospital, Grosse Pointe Farms; Ronald Zack, WSU, Emma L. Bixby Hospital, Adrian; Carol Southland, WSU, and Don Avriett, WSU, Holland City Hospital, Holland; John Bruder, WSU, Leelanau Memorial Hospital, Northport; Gail Paepke, WSU, Pipp Community Hospital, Plainwell; Michael Geheb, WSU, Richard Valentine, WSU, Robert Urban, WSU, and Steven Crane, WSU, Hutzel Hospital, Detroit, and Anson Goodier, Michigan State University, United Memorial Hospital, Greenville.

"From my own experience so far," says Randall Riggs, coordinator for the SAMA-MECO project at WSU, "I can say that this is a most interesting and valuable program, which will provide a good foundation for the clinical work beginning in year two of medical studies."

Doctor Knisely Leaving MSU For Texas Post

William H. Knisely, M.D., director of the Institute of Biology and Medicine at Michigan State University, will take over duties Sept. 1 as vice chancellor for health affairs for the University of Texas.

In his new capacity, Doctor Knisely will be responsible for the overall direction of medical, dental, nursing and other health professional schools located in Galveston, Dallas, San Antonio and Houston. He will also be responsible for administration of the M. D. Anderson Tumor Hospital and Clinic, a graduate school of biological sciences and a new school of public health.

Doctor Knisely joined MSU in 1963 and helped to lay the groundwork for establishment of the College of Human Medicine in 1964.

Doctor Block Succeeds Doctor Irvin As Medical Director of Ford

Doctor Block

Doctor Irvin

Duane L. Block, M.D., Dearborn, has been appointed medical director of the Ford Motor Company, succeeding Earle A. Irvin, M.D., who is retiring after nearly 16 years as head of the Ford corporate medical staff.

Doctor Block has been the physician in charge of medical services at the Ford Rouge complex in Dearborn since joining the company in 1955. He is chairman of the MSMS Committee on Occupational Health and is immediate past president of the Industrial Medical Association, the international organization of industrial physicians.

Doctor Irvin is also a past president of the Industrial Medical Association and in 1969 received its annual award presented to the most outstanding contributor to industrial medicine. He is past president of the Michigan Heart Association, the Michigan Industrial Medical Association and the Michigan Health Council.

Plans Move Ahead For Physician Assistants Program at WMU

Western Michigan University on July 1 filed an official plan with the State Department of Education to enroll the first class of physician assistants in August, 1971.

An advisory committee of physicians and deans at WMU has held its first meeting and will be meeting again soon to work out the details of the new curriculum, the first of its kind in the nation. The physician assistants program was conceived by William G. Birch, M.D., Kalamazoo, who won the support of MSMS for the idea and became chairman of the MSMS Committee on Physician Assistants, which led the planning.

Doctor Ryan Heads WSU Medical Alumni

Jack Ryan, M.D., Warren, is new president of the Wayne State University School of Medicine Alumni Association. He was elected at the Annual Alumni Clinic Day sponsored recently by the alumni association.

Other new officers include Frank B. Walker II, M.D., Grosse Pointe Park, honorary president and past president; Lawrence Gardner, M.D., Lathrup Village, president-elect, and secretary, Robert L. Lucas, M.D., Detroit. Warren O. Nickel, M.D., continues as treasurer.

New governors elected to the nine-man board of governors are Arnold R. Axelrod, M.D., Detroit, Yoshikazu Morita, M.D., Detroit, and Robert W. Clifford, M.D., Owosso.

During an intermission at the Michigan Heart Association Scientific Sessions in Cobo Hall, Detroit, recently, W. Dudley Johnson, M.D., right, of Marquette University School of Medicine, details his work for five Michigan physicians. Doctor Johnson, who has been successful with grafting saphenous vein segments to bypass coronary artery blockage in 500 patients, spoke at the MHA Scientific Sessions. Conrad R. Lam, M.D. in background, surgeon in charge, Division of Thoracic Surgery, Henry Ford Hospital, was program committee chairman. The MHA Scientific Sessions enjoyed their largest turnout ever, with nearly 4,800 persons in attendance. The program included a discussion of new developments in the treatment of stroke victims and a day-long session for nurses.

Lenore Romney, Martha Griffiths to Address MDPAC Luncheon Sept. 23 in Detroit

Two women prominent in Michigan politics — Lenore Romney, candidate for the U. S. Senate from Michigan; and U. S. Congresswoman Martha W. Griffiths (D-Detroit)— will speak at the MDPAC Luncheon during the 1970 MSMS Annual Session.

Scene of the MDPAC meeting at noon Wednesday, Sept. 23, will be the Sheraton-Cadillac Hotel, Detroit, where the MSMS Annual Session is scheduled to convene Sept. 20-24.

The luncheon will take the place of the 1969 MDPAC breakfast, and will be held for MDPAC members and their wives. Special guests from the national organization, AMPAC, are expected.

Louis R. Zako, M.D., Allen Park, is luncheon chairman. On his committee are Alexander Blain, III, M.D., Detroit; William O. Mays, M.D., Detroit; Donato F. Sarapo, M.D., Adrian; Thomas R. Berglund, M.D., Kalamazoo; Jack M. Stack, M.D., Alma; Paul T. Lahti, M.D., Royal Oak, and Mrs. Edward R. Weddon, Stockbridge, president of the Woman's Auxiliary to MDPAC.

Tickets, which are $5, should be reserved early with MDPAC, Box 769, East Lansing 48823.

NMA To Build First Black Medical Center On East Side of Detroit

The nation's first medical center for black persons is to be built soon in the historic Indian Village section of Detroit. It will be the initial one of several such facilities planned across the nation by the National Medical Association Foundation.

The center will serve up to 200 indigent persons and private patients from Negro areas throughout the east side. It will provide space for complete facilities for 12 physicians, nursing laboratory, office staffs, a psychiatric staff and a social assistance staff which would direct the impoverished to government agencies able to underwrite costs.

White physicians will be considered to serve in the center, but it will be primarily directed towards black physicians and patients. Construction of the $1 million two-story center was to begin by July.

AN ARTIST'S RENDERING of the health sciences complex proposed for Michigan State University shows the two wings of the Life Sciences I Building, which is now under construction, at the left foreground. It is joined by Life Sciences II, left above, and by the university health center to the right.

MSU Receives Notice of Eligibility For Funds to Continue Medical Complex

Michigan State University has been notified that it is eligible for about $27.4 million in federal funds for construction of a university health center and a second life sciences building, according to President Clifton R. Wharton, Jr.

The National Advisory Council on Education for Health Professions has recommended federal funding of the two buildings for MSU's medical and related health sciences program. The health center would include a combination teaching hospital and outpatient clinic.

Actual receipt of the $27.4 million, however, is dependent on the availability of additional federal funds for medical school construction and of matching funds from state and private sources.

Add In Memoriam

Since the July issue of *Michigan Medicine* was prepared, the following news has reached MSMS Headquarters:

Watson Beach, M.D., Grosse Pointe Woods, 73, died June 22
Walter A. Briegel, M.D., Birmingham, 84, died June 3
Kenneth N. Campbell, M.D., Bloomfield Hills, 57, died June 25
Harold T. Crews, M.D., Birmingham, 78, died June 5
Arthur C. Curtis, M.D., Ann Arbor, 72, died July 7
Henry J. Flaherty, M.D., Farmington, 61, died May 26
Ledru O. Geib, M.D., Detroit, 88, died May 25
W. William MacGregor, M.D., Birmingham, 83, died June 8
Pedro Meza, M.D., Port Huron, 46, died June 14
Carl A. Moyer, M.D., Baraga, 61, died May 29
Remus G. Robinson, M.D., Detroit, 66, died June 7
John A. Scott, M.D., Jackson, 66, died May 21
Roger S. Siddall, M.D., Sumter, S.C., 75, died May 15
Edward F. Swickle, M.D., Royal Oak, 59, died June 12
Kenneth N. Wells, M.D., Grand Haven, 62, died May 28

Bills to Restructure Blue Shield, Blue Cross Boards Pass House, Now in Senate Commerce Committee

The House bills, HB 4627 and HB 4628, to change the structures of the boards of Blue Shield and Blue Cross, are in the Senate Commerce Committee, awaiting the reconvening of the Michigan Legislature early in August.

The two bills were passed by the House in its spring, 1970, session, and would allow the governor to appoint the Blue Shield and Blue Cross boards. There would also be a significant increase of lay members on the boards.

CAPSULES

Robert J. Mason, M.D., Birmingham, MSMS president, has been elected to the Board of Trustees of Rush Medical College, Chicago. Doctor Mason was elected at the meeting of the medical alumni and faculty in Chicago during the AMA annual meeting. He will play an important part in the re-establishment of the medical college, which will admit its first class in 1971.

* * *

New president of the Michigan Hospital Association is Julien Priver, M.D., executive vice president of Sinai Hospital, Detroit. He was installed at the MHA's 51st annual meeting on Mackinac Island.

* * *

Michigan physicians may submit abstracts until Sept. 1 for the 10th Annual Wayne State University Thyroid Workshop scheduled Dec. 9 at the Wayne County Medical Society Auditorium in Detroit. The abstracts may be sent to Nelson Taylor, M.D., 722 Notre Dame Ave., Grosse Pointe 48230.

* * *

Clyde T. Hardwick, Ph.D., MSMS Economic Consultant, is new dean of the College of Business at Michigan Technological University, Houghton. Doctor Hardwick was formerly dean of the College of Business at Wayne State University.

* * *

Mrs. Mary E. Jordan, Eaton Rapids, immediate past president of the State of Michigan Chapter, American Association of Medical Assistants, received the Outstanding Medical Assistant of the Year award from the Michigan medical assistants' organization at their annual convention.

* * *

The cover of the July issue of *Michigan Medicine* helps to call the attention of MSMS members to the 1970 Annual Session in Detroit, September 20-24. The attractive art work on the cover was available through the courtesy of the Medical Society of the State of New York.

The resources of the American Medical Association, through its continual output of printed materials, are available to aid Michigan physicians in their relationships with their patients and the general public. Check any item(s) desired from the list below and mail to MSMS, 120 W. Saginaw St., East Lansing 48823. (Your address is already on the back.)

______ **AMA folder describing Arthritis to patients.**

______ **AMA folder discussing concerns for school educational programs, entitled "Why Health Education?"**

______ **Explanatory booklet telling physicians how they can use the AMA Library.**

______ **New AMA Catalog of health educational materials.**

MSMS Presents Franz J. Ingelfinger, M.D. In First Annual Discourse Sept. 23 in Detroit

Doctor Ingelfinger

The editor of the highly-acclaimed *New England Journal of Medicine,* Franz Joseph Ingelfinger, M.D., will be the speaker for a new feature of the 1970 MSMS Annual Session – the Annual Discourse.

Doctor Ingelfinger will speak at 10:15 a.m. Wednesday, Sept. 23 in the Grand Ballroom of the Sheraton-Cadillac Hotel, Detroit, scene of the Annual Session Sept. 20-24. His topic will be "The Nurture of the Social Doctor."

"One of the things that concerns me, for example, and which I might wish to discuss," he has said, "is the kind of reporting that physicians see in their professional literature concerning the social-political-economic aspects of medical practice. By and large, such information is extremely limited and such accounts as the physicians are apt to see, often distributed by the AMA, are apt to be slanted.

"What is said is true enough," continued Doctor Ingelfinger, "but the viewpoints of the opposition are entirely ignored. Under such circumstances, I feel doctors suffer because they cannot come to grips with the argument of the opposition."

Doctor Ingelfinger's *New England Journal of Medicine* is published weekly from Boston.

He is a full member of the Commission on Enteric Infections of the Armed Forces Epidemiological board; national consultant to the Surgeon General, USAF, and member of the Biomedical Communications Study Section of the Public Health Service.

Doctor Ingelfinger is former president of the American Gastroenterological Association and former president of the Inter-American Association of Gastroenterology. In 1969 he received the Friedenwald Medal in Gastroenterology from the AGA. He serves as a clinical professor of medicine at Boston University School of Medicine. He was born in Dresden, Germany and came to the United States in 1922, receiving his medical degree from Harvard University in 1936.

Doctor Winkler Selected As UP Society President

Henry J. Winkler, M.D., L'Anse, has been selected new president of the Upper Peninsula Medical Society, and will take over duties when he is also installed as president of the Baraga County Medical Society on Sept. 1.

Doctor Winkler, who was elected at the 75th annual meeting of the Upper Peninsula Medical Society June 18-20 at Sault Ste. Marie, will preside over the 76th annual meeting in Houghton. The date for the 1971 meeting has not yet been announced.

Approximately 30 Upper Peninsula physicians attended the 1970 meeting, which had as special guests 11 young Sault Ste. Marie persons who are now practicing physicians.

---

michigan medicine

MICHIGAN STATE MEDICAL SOCIETY

Published semi-monthly, Trimonthly in December; 25 issues, by the Michigan State Medical Society as its official journal. Second class postage paid at East Lansing, Mich. and at additional mailing offices. Yearly subscription rate, $9.00. Printed in USA. All communications should be addressed to the Publications Committee, Michigan State Medical Society, 120 West Saginaw Street, East Lansing, Michigan 48823. © 1970 Michigan State Medical Society. Phone: Area Code 517, 337-1351.

Second Class Postage Paid at East Lansing, Mich.
and at additional mailing offices.

UNIVERSITY OF CAL
LIBRARY SCH OF MED
THIRD & PARNASSUS AVE
SAN FRANCISCO CAL 94122

Breaking News: Deadline July 22
August 1970, Volume 69, Number 15
Michigan State Medical Society

michigan medicine

MSMS Scientific Session Sept. 23-24 To Include Many Out-of-State Speakers

Medical experts in many fields will gather in Detroit Sept. 23-24 from around the nation. They will speak at the Scientific Sessions concluding the 1970 MSMS Annual Session scheduled Sept. 20-24 at the Sheraton-Cadillac Hotel.

The physicians will bring new viewpoints and knowledge to general sessions, specialty meetings, all-day postgraduate courses, discussions of medical controversies and new medical developments, all planned in the big two-day scientific program.

Among the states represented by the speakers will be Ohio, Indiana, Illinois, Wisconsin, New York, Pennsylvania, Delaware, Maryland, Massachusetts and Missouri.

Headliner for the Scientific Sessions will be Franz J. Ingelfinger, M.D., Boston, editor of *The New England Journal of Medicine* and speaker for the first MSMS Annual Discourse. Topic of his talk, scheduled at 10:15 a.m., Sept. 23 in the Grand Ballroom of the Sheraton-Cadillac will be "The Nurture of the Social Physician."

One speaker, T. G. Parks, M.Ch., F.R.C.S., will travel all the way from Belfast, Ireland, to speak at the MSMS meeting. His topic will be "Problems of Diverticular Disease."

Among out-of-state speakers will be:

Ian M. Thompson, M.D., professor and chairman, Section of Urology, University of Missouri-Columbia School of Medicine;

J. M. Maas, M.D., Medical Research Division, The Lilly Research Laboratories, Eli Lilly and Co., Indianapolis;

John C. Sinclair, M.D., assistant professor of pediatrics, Columbia Medical Center, New York City;

Jordan N. Fink, M.D., associate professor of medicine, Marquette School of Medicine and chief of Allergy Section, Wood Veterans Administration Hospital, Milwaukee;

Roger Revelle, Ph.D., Harvard Population Center, Boston;

J. Beach Hazard, M.D., senior consultant in pathology, Division of Laboratory Medicine, Cleveland Clinic Foundation, and clinical professor of pathology, Case Western Reserve School of Medicine, Cleveland;

D. Carleton Gajdusek, M.D., director of the Laboratory of Slow, Latent and Temperate Virus Infections and of Study of Child Growth and Development and Disease Patterns in Primitive Cultures, National Institutes of Neurological Diseases and Stroke, Bethesda.

Arrangements are being completed to secure additional outstanding speakers for the Scientific Sessions.

The Registration booth was one of the busiest spots during the 1969 MSMS Annual Session in Detroit, as MSMS staff members welcomed the physicians attending the meetings. A full informational program of panels, demonstrations and speakers on controversial and important subjects is planned for the 1970 Annual Session Sept. 20-24 in Detroit.

ION
REGISTRATION
REGISTRATIO

Doctor McLean, M.D., left, and Alfred H. Whittaker, M.D., member of the WSU Board of Governors, stand proudly before the Stapleton Reading Room at the recent opening of the Shiffman Medical Library. The Stapleton Room, named in honor of William J. Stapleton, Jr., M.D., former president of the Wayne County Medical Society and former associate dean of the WSU School of Medicine, has been designated as a reading room for doctors. The walnut-paneled room will be furnished through gifts of the Wayne County Medical Society.

Abraham Shiffman of Southfield (second from left) cuts the ribbon that officially opened Wayne State University's Vera Parshall Shiffman Medical Library in the Detroit Medical Center. Shiffman was aided at the July ceremonies by Vern M. Pings (left), WSU's medical librarian; Wayne State President William R. Keast; and Don W. McLean, M.D., of Lathrup Village, representing the alumni library fund raising committee.

WSU's Shiffman Medical Library Opens

An important addition to the Detroit Medical Center was added recently with the opening of Wayne State University's Vera Parshall Shiffman Medical Library.

The $2.25 million building, located at Canfield and Brush Streets, presently houses 100,000 volumes on three floors, with space for 180,000. More than $200,000 toward its cost was raised by Wayne medical alumni, the Shiffman Foundation donated $500,000 towards the cost and other funds were provided by HEW.

Features of the library include "open stacks," large reading rooms, a History of Medicine section, conference and study rooms and the Stapleton Room. (See picture)

Location of the WSU medical library in the heart of the medical center, close to the WSU Medical Research and Basic Medical Sciences buildings, will allow it to serve more doctors and students.

Official Call

The Michigan State Medical Society will convene in Annual Session in Detroit, Michigan, September 20-24, 1970. The provisions of the Constitution and Bylaws and the Official Program will govern the deliberations.

ROBERT J. MASON, M.D.
President

ROSS V. TAYLOR, M.D.
Council Chairman

JAMES B. BLODGETT, M.D.
Speaker

VERNON V. BASS, M.D.
Vice Speaker

Attest:
Kenneth H. Johnson, M.D., Secretary

CAPSULES

The Michigan Heart Association will sponsor another in its three-day physician education courses on Decision Making in Acute Coronary Care Aug. 13-15 at the Hotel Dickinson in Iron Mountain. Faculty for the course, approved for prescribed (Category 1) credit by the American Association of General Practitioners, will be comprised of physicians from throughout Michigan.

* * *

William H. Carlyon, M.D., a consultant in health and physical fitness for the AMA since 1966, took over duties July 1 as public affairs director for the Michigan Dental Association. Mr. Carlyon, who holds a Ph.D. degree in health education from Southern Illinois University, is a native of Muskegon.

* * *

Wayne State University School of Medicine is one of 43 medical schools across the nation which will share in $15 million in "disaster grants" from the federal government in 1970-71.

Wayne has reportedly asked Washington for $600,000 in emergency aid, though the exact amount it will receive was not known at the time of this reporting.

Women to Meet Sept. 22-24

Environment, Homemaker Service Among Subjects for Auxiliary Convention

Members of the Woman's Auxiliary to the Michigan State Medical Society will meet for their 44th annual convention Sept. 22-24 at the Pontchartrain Hotel, Detroit.

Their annual meeting is planned to run concurrently with the Scientific Sessions of the Michigan State Medical Society, which will be held Sept. 23 and 24 at the nearby Sheraton-Cadillac Hotel.

Registration will be held from noon to 4 p.m. Tuesday, Sept. 22, from 8 a.m. to 4 p.m. Wednesday and from 8 a.m. to noon Thursday in the lobby of the Pontchartrain, for the auxiliary convention.

Highlights of the meeting will include a talk on "Environmental Ecology" by David M. Serotkin, state legislator from Mt. Clemens, at 10 a.m. The Thursday noon luncheon will be followed by a talk by Mrs. Fran Harris and Miss Adele Aras of the Metropolitan Detroit Homemaker Service, who will relate experiences of their service career, with the hope of influencing auxiliary members to initiate Homemaker Services in their communities.

Mrs. Chester Young, Kansas City, Kansas, vice president of the North Central Region of the Woman's Auxiliary to the AMA, will deliver the keynote speech Wednesday morning and a fashion show will follow the Wednesday noon luncheon honoring Mrs. Young, past state presidents and state secretaries.

Mrs. F. P. Rhoades of Detroit will be installed as new president of the Woman's Auxiliary to MSMS, succeeding Mrs. Edward Maxim of Mt. Clemens. Mrs. Rhoades is a former employe of the *Detroit Times,* former major with the Red Cross Motor Corps and holds a Basic Seamanship Certificate with the Coast Guard Auxiliary.

Women attending the convention will also have the opportunity to view films from the AMA pertaining to topics of current high interest, such as drug abuse and health careers.

Convention chairman is Mrs. Donald Bolstad of Dearborn, who is assisted by co-chairman Mrs. Winthrop Hall, Dearborn.

International Drug Abuse Symposium Scheduled Nov. 9-13 at U-M

An international symposium on drug abuse will be held at the Towsley Center for Continuing Medical Education in The University of Michigan Medical Center, Nov. 9-13.

Over one year in preparation, the U-M drug symposium will feature specialists from the United States, England, Sweden, Switzerland and Japan. Experts from the world drug scene will cover all aspects of this problem, including the medical, pharmacologic, psychiatric, legal and social aspects of drug abuse.

Although technical aspects of the drug abuse problem will be handled in depth in the sessions of the symposium, its overall objective is to assist the practicing physician in coping with drug abuse in patient care.

MSMS Orient Adventure Approaching on Fall Calendar

Staff Assistant to the MSMS Group Travel Committee, Helen A. Schulte, returned July 16 from a two-week trip to Japan and Hong Kong, where she checked facilities and arrangements for the forthcoming 1970 MSMS Orient Adventure.

A large number of MSMS members and their spouses have made reservations for the Oct. 5-19 luxury visit to the Far East and openings are still available for those who wish to go. Registration forms were published in the May and June issues.

MICHIGAN MEDICINE is published Semi-Monthly, Trimonthl
December; 25 issues, by the Michigan State Medical Society,
W. Saginaw, East Lansing, Mich. 48823. Second class postage
at East Lansing, Mich. and at additional mailing offices.

Lutrexin®

HW&D BRAND OF LUTUTRIN

3000 UNIT TABLETS

IN THE TREATMENT OF FUNCTIONAL DYSMENORRHEA AND SELECTED CASES OF PREMATURE LABOR AND 2ND AND 3RD TRIMESTER THREATENED ABORTION

- LUTREXIN, the non-steroid "uterine relaxing factor" has been found to be useful by many clinicians in controlling abnormal uterine activity.
- Literature on indications and dosage available on request.
- No side effects have been reported, even when massive doses (25 tablets per day) were administered.
- Supplied in bottles of twenty-five 3,000 unit tablets.

(In vivo measurement of Lutrexin on contracting uterine muscle of the guinea pig.)

HYNSON, WESTCOTT & DUNNING, INC. HW&D BALTIMORE, MARYLAND 21201

(LTR23)

A urinary tract infection was eliminated last week

Intestinal monilial overgrowth has appeared this week

For women who are diabetic or debilitated, oral antibiotic therapy often sets the stage for monilial overgrowth in the intestine.

When you anticipate such a problem, take action with DECLOSTATIN 300. It combines the broad-spectrum potency of demethylchlortetracycline with the antifungal effectiveness of nystatin—it helps avoid monilial take-over. Experience has shown DECLOSTATIN to be highly useful for many women patients; individual culture studies will show exactly where this usefulness may best be applied.

It doesn't let monilia begin where bacteria end.

Declostatin® 300

Demethylchlortetracycline HCl 300 mg and Nystatin 500,000 units Capsule-Shaped Tablets Lederle

Effectiveness: Because its antibacterial component is DECLOMYCIN® Demethylchlortetracycline, DECLOSTATIN should be equally or more effective therapeutically than other tetracyclines in infections caused by tetracycline-sensitive organisms. The antifungal component, nystatin, protects against superinfection by antibiotic-resistant fungal overgrowth (particularly monilia) in the intestinal tract.

Contraindication: History of hypersensitivity to demethylchlortetracycline or nystatin.

Warning: In renal impairment, usual doses may lead to excessive accumulation and liver toxicity. Under such conditions, lower than usual doses are indicated and, if therapy is prolonged, serum level determinations may be advisable. A photodynamic reaction to natural or artificial sunlight has been observed. Small amounts of drug and short exposure may produce an exaggerated sunburn reaction which may range from erythema to severe skin manifestations. In a smaller proportion, photoallergic reactions have been reported. Patients should avoid direct exposure to sunlight and discontinue drug at the first evidence of skin discomfort. Necessary subsequent courses of treatment with tetracyclines should be carefully observed.

Precautions: Overgrowth of nonsusceptible organisms may occur. Constant observation is essential. If new infections appear, appropriate measures should be taken. In infants, increased intracranial pressure with bulging fontanels has been observed. All signs and symptoms have disappeared rapidly upon cessation of treatment.

Side Effects: Gastrointestinal system—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. Skin—maculopapular and erythematous rashes; a rare case of exfoliative dermatitis has been reported. Photosensitivity; onycholysis and discoloration of the nails (rare). Kidney—rise in BUN, apparently dose-related. Transient, reversible, nephrogenic diabetes insipidus with excessive thirst and polyuria (rare). Hypersensitivity reactions—urticaria, angioneurotic edema, anaphylaxis. Teeth—dental staining (yellow-brown) in children of mothers given this drug during the latter half of pregnancy, and in children given the drug during the neonatal period, infancy and early childhood. Enamel hypoplasia has been seen in a few children. If adverse reaction or idiosyncrasy occurs, discontinue medication and institute appropriate therapy. Demethylchlortetracycline may form a stable calcium complex in any bone-forming tissue with no serious harmful effects reported thus far in humans.

Average Adult Daily Dosage: One tablet b.i.d. Should be given 1 hour before or 2 hours after meals, since absorption is impaired by the concomitant administration of high calcium content drugs, foods and some dairy products. Treatment of streptococcal infections should continue for 10 days, even though symptoms have subsided.

Lederle LEDERLE LABORATORIES, A Division of American Cyanamid Company, Pearl River, New York

450-9

michigan medicine

SCIENTIFIC EDITOR
John W. Moses, MD

EXECUTIVE EDITOR
Herbert A. Auer

MANAGING EDITOR
Judith Marr

ASSOCIATE SCIENTIFIC EDITORS
Jason Bodzin, MD
Detroit, House Staff
Frederick J. Cady, Jr., MD
Saginaw, Surgery
Robert M. Daugherty, MD
East Lansing, Basic Science
Harold E. DePree, MD
Kalamazoo, Medicine
Dean C. Elliott, MD
Petoskey, Otolaryngology
Tommy N. Evans, MD
Detroit, Obst.-Gyn.
E. Richard Harrell, MD
Ann Arbor, Dermatology
Dorin L. Hinerman, MD
Ann Arbor, Pathology
Samuel D. Jacobson, MD
Detroit, Medicine
Benjamin Jeffries, MD
Detroit, Psychiatry
Raymond S. Kurtzman, MD
Detroit, Radiology
A. Martin Lerner, MD
Detroit, Medicine
Charles E. Parkinson, MD
Battle Creek, Radiology
John C. Peirce, MD
Grand Rapids, Medicine
Frank H. Power, MD
Traverse City, Surgery
J. G. Turcotte, MD
Ann Arbor, Surgery
Alexander J. Walt, MD
Detroit, Surgery
Park W. Willis, III, MD
Ann Arbor, Medicine
Richard E. Wunsch, MD
Traverse City, Medicine

PUBLICATION COMMITTEE
Brooker L. Masters, MD
Chairman
Robert M. Leitch, MD
William A. LeMire, MD
Don Marshall, MD
Don W. McLean, MD
Milton R. Weed, MD

MICHIGAN MEDICINE is the official organ of the Michigan State Medical Society, published under the direction of the Publication Committee. Published Semi-Monthly, Trimonthly in December; 25 issues, by the Michigan State Medical Society as its official journal. Second class postage paid at East Lansing, Mich. and at additional mailing offices. Yearly subscription rate, $9.00; single copies, 80 cents. Additional postage: Canada, $1.00 per year; Pan-American Union, $2.50 per year; Foreign, $2.50 per year. Printed in USA. All communications relative to manuscripts, advertising, news, exchanges, etc., should be addressed to Publication Committee, Michigan State Medical Society, 120 West Saginaw Street, East Lansing, Michigan 48823. Phone Area Code 517, 337-1351. © 1970 Michigan State Medical Society

* * *

MICHIGAN MEDICINE welcomes original scientific manuscripts, news items, photographs, features and letters presenting comments on issues. Authors may write to the MSMS Headquarters to obtain detailed instructions for the preparation of scientific papers.

IN THIS ISSUE

SCIENTIFIC ARTICLES

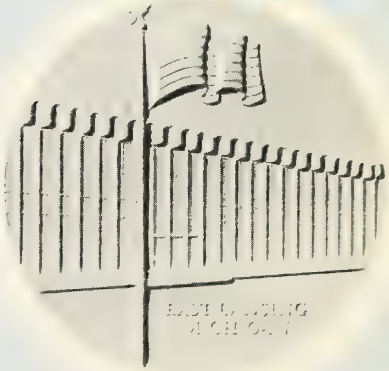
657 Chronic Granulomatous Disease of Childhood; Gerald Light, M.D.; Roman Knoblich, M.D.
661 Prosthetic Replacement of the Mitral Valve; Andrew G. Morrow, M.D.
665 Morphological Alterations of Red Cells; N. A. Nelson, M.D.; M. A. Khan, M.D.; G. A. Stair, M.D.; D. H. Woodbury, M.D.; L. Kole, M.D.; T. Meadows, M.D.
669 Resection of the Ascending Colon for Pneumatosis Cystoides Intestinalis; Z. Steiger, M.D.; N. M. Jackiw, M.D.; Walter H. Gerwig, Jr., M.D.; T. C. Knechtges, M.D.
673 Hospital Care in Michigan in 1967 for Cerebrovascular Disease; Charles M. Wylie, M.D., Dr.Ph.; Kenneth W. Teich, M.D.
678 Effect of Histamine and Aspirin on Healing of Acute Acetic Acid Ulcers in Dogs; Choichi Sugawa, M.D.; Charles E. Lucas, M.D.; Alexander J. Walt, M.D., F.A.C.S.

SPECIAL ARTICLES

703 129 Michigan Communities Seeking General Practitioners; 68 Need Specialists
714 Environment and Health; Maurice S. Reizen, M.D.; John L. Isbister, M.D.

OTHER FEATURES

639 breaking news
646 your opinion please
648 msms leadership
649 officers' page
654 county societies
664 The Viewbox
668 Perinatal Tips
672 Monthly Surveillance Report
678 Michigan Authors
685 council minutes
686 msms news
michigan mediscene
689 about doctors
692 mailbag
696 medical care programs
711 medico-legal
719 editorial viewpoints
722 in memoriam
726 noted and quoted



MICHIGAN STATE MEDICAL SOCIETY
120 West Saginaw (P.O. Box 152)
East Lansing, Mich. 48823
Area Code 517, 337-1351

your opinion please

QUESTION: Suggest at least one way in which you believe the health care system could revolutionize itself to become more responsive to the health needs of a rapidly evolving society.

George T. Kelleher, M.D. Battle Creek

Almost 24 centuries have passed since Thucydides observed that because of human nature the things which had happened once (Athens' plunge to Pelopponesian destruction) would happen again.

It does not require an overwhelming cognitive exercise to demonstrate that once again, "the things" are happening. Implicit in Thucydides' observation are 1) there must be something good for the bad things to destroy and 2) the good things which are cyclically destroyed must have replaced some pre-existing bad things.

The only way the health care system can become responsive to "a rapidly evolving society" is to make it plain to all that our society, including the "health care system," has engaged itself in a regressive process which has reached the point that the sooner the bad things are replaced by good things the less likely we are to descend completely to a dreary collectivism which is the certain end point of the current application of intellectual indigency; this indigency is philosophically improper, ethically dishonest and pragmatically infeasible.

The health care system is in a unique position to accomplish refurbishment of itself, and of all society, by recognizing the availability of a tool which has been used to downgrade the total system: The Consensus.

The Consensus is described by writer Tom Wicker as any socio-political action which is not offensive to any major segment of the socio-political whole. Mr. Wicker speaks in quantitative terms. The two or three hundred thousand physicians in this land are a qualitative segment of the socio-political whole. This qualitative segment is obliged to announce that it is offended and is obliged to draw a firm line and is obliged to exert leadership in replacing the bad things with good things.

Let us hope that a time has arrived when the good-bad cycle can be broken in favor of the good, the savagery of vulpine democracy can be replaced by a true polity with equal justice, and with privilege equated with responsibility. Let us recognize the potential of our leadership role and offer that leadership.

William S. Jones Menominee

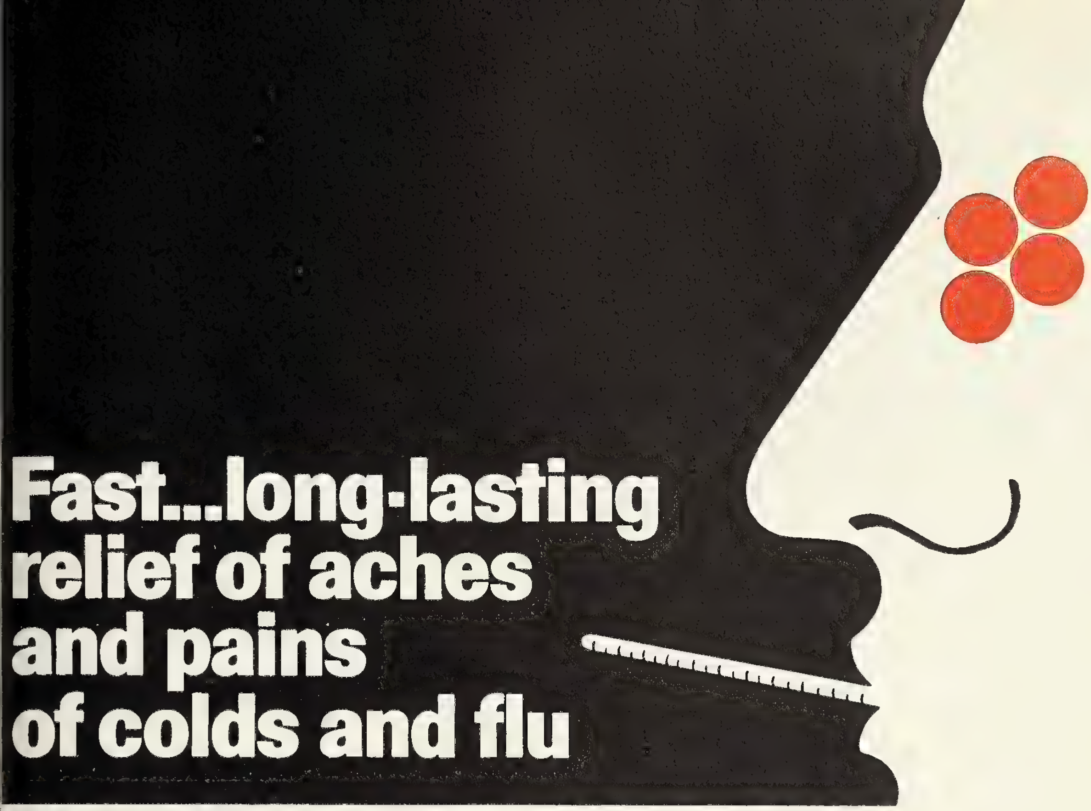
Every year I think I see more hypochondriacs and nervous patients than the year before. For some reason we seem to be contributing to and not solving the problems of these patients with shots and pills. Patients are being encouraged to expect and demand medical attention, sometimes beyond reason, especially when provided at someone else's expense.

The practice of medicine is being exploited by some physicians. Hospitals have been known to encourage overutilization of some of the services they provide. Various governmental health agencies overlap one another and use multiple standard benefits for services provided by the physician. Is it any wonder that the image of the doctor has been battered unmercifully by the press and TV?

Adequate funds are appropriated and are available for health care in this country. But because many of the health plans are discriminatory, and most at best are poorly managed, it would appear to many that health care is inadequate. The net result means National Health Insurance in the very near future.

As individual physicians our recourse is the A.M.A. But this organization has become rather docile and indecisive since the Federal government ligated its vas several years ago. The A.M.A. has failed to unite the profession, it has been unable to provide courageous leadership, and it has offered no satisfactory alternative to National Health Insurance.

(Continued on Page 650)



Fast...long-lasting relief of aches and pains of colds and flu

with the unique timed-release aspirin

Double strength Measurin timed-release aspirin offers a new kind of control for your patients with cold and flu discomforts. In each 10-grain tablet are over 6,000 microscopic reservoirs that release aspirin at a controlled rate—some right away and some later on. This means fast relief of symptoms, followed by hours of comfort. Throughout the day, Measurin gives your patients freedom from a 4-hour aspirin schedule. During the night, its 8-hour dosage schedule holds the promise of sound sleep without awakening to take extra tablets.

For Professional Samples write:
Breon Laboratories Inc.
Sample Fulfillment Division
P.O. Box 141
Fairview, N.J. 07022

BREON **BREON LABORATORIES INC.**
90 Park Avenue, New York, N.Y. 10016
Subsidiary of Sterling Drug Inc.

MEASURIN®
TIMED-RELEASE ASPIRIN

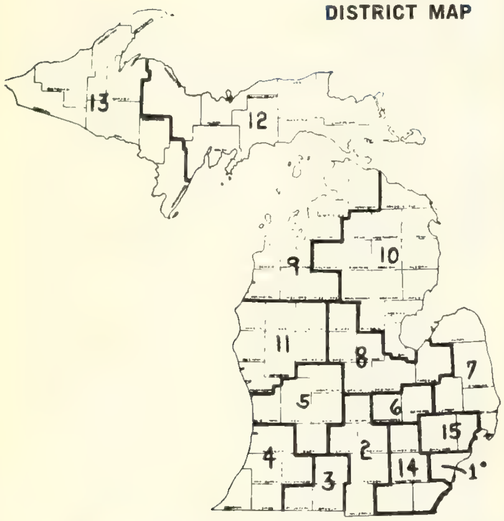
ECONOMICAL • EFFECTIVE • LONG LASTING PAIN RELIEF

Dosage: 2 tablets followed by 1 or 2 tablets every 8 hours as required, not to exceed 6 tablets in 24 hours. For maximum nighttime pain relief, 2 tablets at bedtime.
Available: Bottles of 12, 36 and 60 tablets.

msms leadership

PRESIDENT	Robert J. Mason, M.D.	Birmingham
PRESIDENT-ELECT	Harold H. Hiscock, M.D.	Flint
SECRETARY	Kenneth H. Johnson, M.D.	Lansing
ASST. SECRETARY	Brooker L. Masters, M.D.	Fremont
TREASURER	John R. Ylvisaker, M.D.	Pontiac
ASST. TREASURER	C. Allen Payne, M.D.	Gd. Rapids
SPEAKER	James B. Blodgett, M.D.	Detroit
VICE-SPEAKER	Vernon V. Bass, M.D.	Saginaw
PAST PRESIDENT	James J. Lightbody, M.D.	Detroit
COUNCIL CHR.	Ross V. Taylor, M.D.	Jackson
VICE-CHAIRMAN	Ralph R. Cooper, M.D.	Detroit

COUNCILOR DISTRICT MAP



First District Councilors: (Wayne County)
Sidney Adler, MD, Detroit
Ralph R. Cooper, MD, Detroit
Don W. McLean, MD, Detroit
Milton R. Weed, MD, Grosse Pointe Park
Robert K. Whiteley, MD, Detroit

Second District Councilor: Ross V. Taylor, MD, Jackson
Counties: Clinton, Eaton, Hillsdale, Ingham, Jackson
Third District Councilor: Robert M. Leitch, MD, Union City
Counties: Branch, Calhoun, St. Joseph
Fourth District Councilor: Don Marshall, MD, Kalamazoo
Counties: Allegan, Berrien, Cass, Kalamazoo, Van Buren
Fifth District Councilor: John R. Pedden, MD, Grand Rapids
Counties: Barry, Ionia-Montcalm, Kent, Ottawa
Sixth District Councilor: Ernest P. Griffin, Jr., MD, Flint
Counties: Genesee, Shiawassee
Seventh District Councilor: John J. Coury, MD, Port Huron
Counties: Huron, Sanilac, Lapeer, St. Clair
Eighth District Councilor: A. Carl Stander, MD, Saginaw
Counties: Gratiot-Isabella-Clare, Midland, Saginaw, Tuscola
Ninth District Councilor: Adam C. McClay, MD, Traverse City
Counties: Grand Traverse-Leelanau-Benzie, Manistee, Northern Michigan (Antrim, Charlevoix, Cheboygan and Emmet combined), Wexford-Missaukee
Tenth District Councilor: Robert C. Prophater, MD, Bay City
Counties: Alpena-Alcona-Presque Isle, Bay-Arenac-Iosco, North Central Counties (Otsego, Montmorency, Crawford, Oscoda, Roscommon, Ogemaw, Gladwin and Kalkaska, combined)
Eleventh District Councilor: Brooker L. Masters, MD, Fremont
Counties: Mason, Mecosta-Osceola-Lake, Muskegon, Newaygo, Oceana
Twelfth District Councilor: William A. LeMire, Sr., MD, Escanaba
Counties: Chippewa-Mackinac, Delta-Schoolcraft, Luce, Marquette-Alger
Thirteenth District Councilor: J. Robert Franck, Jr., MD, Wakefield
Counties: Dickinson-Iron, Gogebic, Houghton-Baraga-Keweenaw, Menominee, Ontonagon
Fourteenth District Councilor: Harold F. Falls, MD, Ann Arbor
Counties: Lenawee, Livingston, Monroe, Washtenaw
Fifteenth District Councilor: Sydney Scher, MD, Mount Clemens
Counties: Macomb, Oakland

DIRECTOR
Warren F. Tryloff..........East Lansing
GENERAL COUNSEL
Lester P. Dodd.................Detroit
LEGAL COUNSEL
A. Stewart Kerr.................Detroit

ECON. CONSULTANT
Clyde T. Hardwick ....Detroit
HISTORIAN
Wm. J. Stapleton, Jr., MD ....Detroit
ASS'T HISTORIAN
Wm. M. LeFevre, MD ....Muskegon

SCIENTIFIC EDITOR
John W. Moses, MD ....Detroit

To Hugh with Thanks;
To Warren with Thoughts of the Future

As president, I wish to take this opportunity to sincerely thank Hugh W. Brenneman for his contributions to MSMS over the past 24 years; and to offer our full cooperation to Warren F. Tryloff, our new MSMS director.

Perhaps not all of you know that Mr. Brenneman resigned in mid-June after announcing his candidacy for the Michigan Senate, and The MSMS Council elevated Mr. Tryloff after six years as the associate director.

Hugh Brenneman served the medical profession well and faithfully for a quarter century. He first joined us as the public relations counsel and served with distinction for 16 years. Six years ago he was named the executive officer to succeed William J. Burns, who retired.

Hugh has a real knack for working with people, interpreting their needs and helping to solve their problems in health, education, government, and communications. Hugh has been the driving force behind the Michigan Health Council and the Michigan Association of the Professions. Helping to represent the physician's point of view, Hugh was a member of the boards and committees of many health and civic groups—United Fund, Red Cross, Cancer Society, Heart Association, and others. Many members know about his outstanding efforts to interpret MSMS concerns through the press, radio and TV and speeches before many groups each year.

It is with sincere regrets and best wishes that The MSMS Council accepted Mr. Brenneman's resignation. We all owe him much.

MSMS is indeed fortunate to have Warren Tryloff available to assume duties as the director. Warren, a former businessman, has been well trained in medical association work by Bill Burns and Hugh. Warren joined MSMS in 1954 to direct the MSMS office in Detroit, then became the associate public relations counsel, and then assistant to the executive director before being promoted six years ago to the associate executive directorship.

Warren knows and understands the operations of the MSMS House of Delegates, MSMS Council, the AMA, MSMS committee work, etc.

Changes in personnel always provide opportunities to restructure the MSMS staff to make it more effective, and The MSMS Council and Warren are making some basic changes in staff assignments and functions. Future articles in *Michigan Medicine* will describe new projected approaches to the interprofessional relationships between the fine staff and the MSMS members.

Hugh, we thank you again!

Warren, we are excited about the future!

Robt. J. Mason, M.D.
MSMS President

The private practice of medicine has changed almost beyond belief during the past several decades, to the extent that the solo practitioner is being phased out. This is happening for many reasons among which are the increasing costs of maintaining a practice and the demand on the physician's time. I think we can expect more corporate community health groups located in or adjacent to hospitals utilizing all the available paramedical personnel. This will afford both the rural and urban areas more efficient total health care.

As individuals, I'm sure many of us have shirked our moral responsibilities in some of these matters. What we urgently need more than funds, personnel, and equipment is a change in attitude regarding our whole social structure if both the providers and recipients of health care are to survive.

John W. Grigg, M.D.
Bay City

Geographical distribution of practicing physicians, specifically the shortage of general practitioners has become an increasingly perplexing problem. A segment of the population in rural, economically depressed areas, and the ghetto admittedly is becoming more deficient in quality health care.

Varied factors are responsible; one is increasing specialization. By changing residency requirements, the medical profession could influence this problem, and help provide a greater latitude of medical care.

It is proposed therefore, that all physicians at the completion of internship, spend two years either in general practice, public health service, or military service. This also would include those physicians contemplating academic and research careers. The program would provide specialty physicians with a broader spectrum of medical experience.

With institution of this program, a return to rotating internships would be desirable. A change in selective service regulations would also be necessary. Draft credit could be granted for general practice time, similar to credit presently given for service in the Peace Corps.

Increasingly we entreat the government to solve problems which result in a preponderance of inefficient bureaucracy; therefore, I believe the medical profession should establish a division of National Health Service Corps. The purpose would be to initiate the proposed two-year general practice program, arrange office facilities, equipment, and impart economic guidance. Minimal capital outlay would be necessary since most office facili-

(Continued on Page 652)

Brief Summary of Prescribing Information—9-9/22/69. For complete information consult Official Package Circular.
Indications: Essential hypertension. Use cautiously in patients with renal insufficiency, particularly if they are digitalized.
Contraindications: Anuria, oliguria, active peptic ulceration, ulcerative colitis, severe depression or hypersensitivity to its components contraindicates the use of Salutensin.
Warnings: Small-bowel lesions (obstruction, hemorrhage, perforation and death) have occurred during therapy with enteric-coated formulations containing potassium, with or without thiazides. Such potassium formulations should be used with Salutensin only when indicated and should be discontinued immediately if abdominal pain, distension, nausea, vomiting or gastrointestinal bleeding occurs. Use cautiously, and only when deemed essential, in fertile, pregnant or lactating patients. *Use in Pregnancy:* Thiazides cross the placenta and can cause fetal or neonatal hyperbilirubinemia, thrombocytopenia, altered carbohydrate metabolism and possibly electrolyte disturbances. Fatal reactions may occur with reserpine during electroshock therapy; discontinue Salutensin 2 weeks before such therapy. Increased respiratory secretions, nasal congestion, cyanosis and anorexia may occur in infants born to reserpine-treated mothers.
Precautions: Azotemia, hypochloremia, hyponatremia, hypochloremic alkalosis and hypokaliemia (especially with hepatic cirrhosis and corticosteroid therapy) may occur, particularly with pre-existing vomiting and diarrhea. Potassium loss or protoveratrine A may cause digitalis intoxication. *Potassium loss responds to potassium-rich foods, potassium chloride or, if necessary, discontinuation of therapy. Stop therapy if protoveratrine A induces digitalis intoxication.* Serum ammonia elevation may precipitate coma in precomatose hepatic cirrhotics. Discontinue therapy 2 weeks before surgery or if myocardial irritability, progressive azotemia or severe depression occur. Exercise caution in patients with chronic uremia, angina pectoris, coronary thrombosis or extensive cerebral vascular disease *or bronchial asthma* and in those with a history of peptic ulceration or bronchial asthma; in post-sympathectomy patients; in patients on quinidine; and in patients with gallstones, in whom biliary colic may occur. Patients who have diabetes mellitus or who are suspected of being prediabetic should be kept under close observation if treated with this agent.
Adverse Reactions: Hydroflumethiazide: Skin rashes (including exfoliative dermatitis), skin photosensitivity, urticaria, necrotizing angiitis, xanthopsia, granulocytopenia, aplastic anemia, orthostatic hypotension (potentiated with alcohol, barbiturates or narcotics), allergic glomerulonephritis, acute pancreatitis, liver involvement (intrahepatic cholestatic jaundice), purpura plus or minus thrombocytopenia, hyperuricemia, hyperglycemia, glycosuria, malaise, weakness, dizziness, fatigue, paresthesias, muscle cramps, skin rash, epigastric distress, vomiting, diarrhea and constipation. *Reserpine:* Depression, peptic ulceration, diarrhea, Parkinsonism, nasal stuffiness, dryness of the mouth, weight gain, impotence or decreased libido, conjunctival injection, dull sensorium, deafness, glaucoma, uveitis, optic atrophy, and, with overdosage, agitation, insomnia and nightmares. *Protoveratrine A:* Nausea, vomiting, cardiac arrhythmia, prostration, blurring vision, mental confusion, excessive hypotension and bradycardia. (Treat bradycardia with atropine and hypotension with vasopressors.)
Usual Dose: 1 tablet b.i.d.
Supplied: Bottles of 60, 600, and 1000 scored 50 mg. tablets.

Salutensin®

hydroflumethiazide, 50 mg./reserpine, 0.125 mg. protoveratrine A, 0.2 mg.

BRISTOL
BRISTOL LABORATORIES
Division of Bristol-Myers Company
Syracuse, New York 13201

The antihypertensive therapy that is easy to live with.*

When successive blood pressure readings confirm essential hypertension, consider Salutensin for:

Easy-to-live-with control. Gradual reduction of blood pressure leading to decisive, comfortable control is the common clinical response.

*Salutensin is usually well-tolerated (however, serious side effects can occur; see adjacent column for brief summary of prescribing information).

Easy-to-live with dosage. Two tablets a day usually achieves control. One to two tablets a day often maintains control without need for additional antihypertensive agents.

Easy-to-live with cost of therapy. The one to two tablets a day maintenance dose makes Salutensin economical to stay with. Important, because long-term control calls for long-term therapy.

Salutensin®

hydroflumethiazide, 50 mg./reserpine, 0.125 mg. protoveratrine A, 0.2 mg.

ties and equipment can be leased. Temporary financial assistance could be provided by the program on a loan or repayment note basis. Each physician would be responsible for practice expenses. Once established, the facility would be self-sustaining. In economically depressed areas, the Medicaid program, or other social service programs would provide the bulk of funds. Some program of guaranteed minimal income would be feasible.

This program would minimize the government's role, and provide an incentive for work not present in most governmental programs. It might by exposure, encourage more physicians in general practice, and could provide financial resources for the future resident. This would decrease the necessity to "moonlight" giving more time for academic contemplation, thus improving quality of specialists.

Paul M. Zavell, M.D.
Harper Woods

The health care system consists of at least five integrated parts; namely, medicine, government, voluntary health agencies, third-party-pay systems and the public. Medicine encompasses medical and nursing schools, post-graduate training, hospitals, nursing homes and private medicine. Government includes public health and truly medical-oriented (not political) legislated programs for the common good. Voluntary health agencies embrace all health agencies dependent solely (or almost so) upon voluntarism. Third-party-pay systems enable a free society to adequately meet the costs of obtaining necessary health care. Finally, the public includes all members of society.

Health care viewed in this light is truly complicated. No one approach could possibly revolutionize it for the general good, but here are a few suggestions that might help.

First, medicine can:

a.) shorten from 8 to 5 or 6 the number of years it takes to become a doctor.

b.) insist that nurses again become just that (and not administrators or supervisors)

c.) require hospital training programs to include a 3 to 6 month period when the trainee leaves the hospital for a medically deficient area (urban or rural) under direct supervision of local doctors, clinics or medical societies.

d.) vigorously encourage periodic voluntary self-education examinations for all M.D.'s.

Second, government must:

a.) recognize that thorough consultation with all parties concerned is necessary *before* medically-oriented programs are legislated (example; Medicare's and Medicaid's almost hopeless financial and administrative problems).

b.) shoulder the total cost (as partial or temporary loan) of educating deserving, but poor, qualified medical students.

Third, voluntary health agencies must:

a.) learn to work together to avoid duplication of effort and cost.

b.) update their programs to include all races and relevant groups in their administration.

c.) adequately recognize and "reward" merit in their volunteers.

Fourth, third-party-pay systems must always deliver what they promise without confusion, fine print, or medical double talk.

Fifth, and finally, the public must be educated to realize there will never be only one answer (medical or financial) for every whim or complaint.

How to Make County Societies More Relevant for Members?

"Your opinion please" is a monthly feature in *Michigan Medicine* designed to provide a forum for the views of Michigan physicians on vital issues. Your comments are invited in response to the question asked on this page.

A question is selected each month and interested physicians are urged to send in their reactions. Letters in response to the question for the October issue must be received in the MSMS office by Sept. 1.

The October question will be:

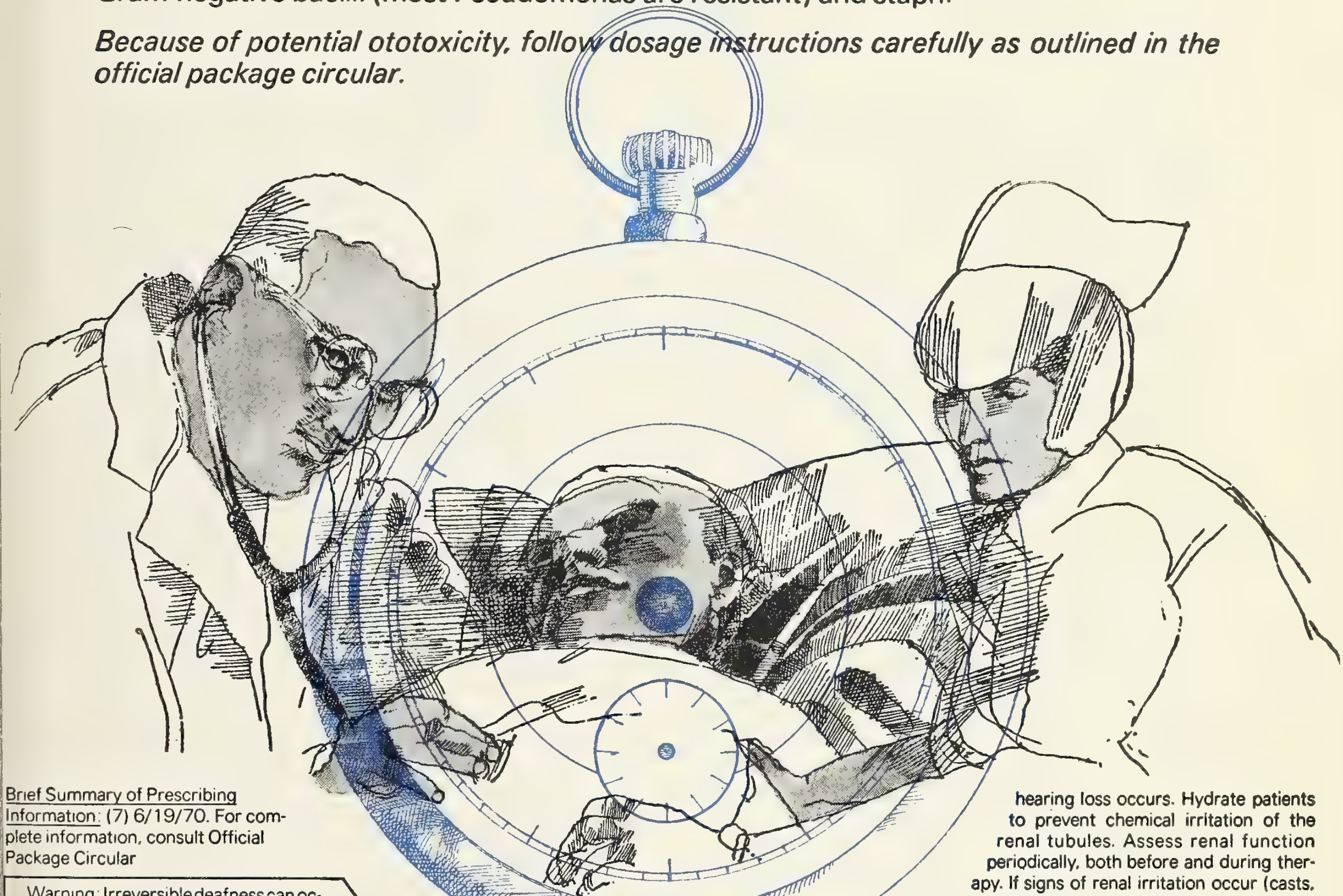
"Suggest one way that you feel county medical societies could change their operations to become more relevant to the needs, problems and opportunities of their members."

A valuable hospital antibiotic —when there is no time

in severe systemic infections—postoperative bacteremia, Gram-negative/staph pneumonias or neonatal sepsis—Kantrex® (kanamycin sulfate) is often indicated before results of customary sensitivity tests can be reported. Clinical response is often seen within 24-48 hours in susceptible infections, with remission soon after.

10 years of experience confirm the continuing effectiveness of Kantrex® against many Gram-negative bacilli (most Pseudomonas are resistant) and staph.

Because of potential ototoxicity, follow dosage instructions carefully as outlined in the official package circular.



Brief Summary of Prescribing Information: (7) 6/19/70. For complete information, consult Official Package Circular

Warning: Irreversible deafness can occur. Tinnitus or vertigo may also occur and indicate vestibular damage and impending deafness. The risk is sharply increased with renal dysfunction. In such cases, decrease size and frequency of doses. Discontinue kanamycin and check hearing if azotemia increases. Watch carefully for ototoxicity in older patients and patients receiving more than 15 Gm. of kanamycin. To avoid neuromuscular paralysis with respiratory depression, postpone intraperitoneal instillation in post-operative patients until recovery from anesthesia and muscle relaxants is complete. Avoid concurrent use of other ototoxic drugs including ethacrynic acid. Safety in pregnancy is not established.

ndications: Serious infections due to susceptible strains of *E. coli*, Proteus sp., *A. aerogenes*, *K. pneumoniae*, *Serratia marcescens* and *Mima-Herellea*. Culture and sensitivity studies should be performed.

Contraindications: A history of hypersensitivity to the drug. Prior auditory damage by kanamycin or other agents may be a contraindication if effective alternative herapy is available.

Precautions: Obtain audiograms before and during therapy in patients with renal dysfunction when treatment lasts more than 5 days. Stop Kantrex if tinnitus or hearing loss occurs. Hydrate patients to prevent chemical irritation of the renal tubules. Assess renal function periodically, both before and during therapy. If signs of renal irritation occur (casts, cells, proteinuria) increase hydration and reduce the dosage or the frequency of dosage if necessary—in azotemic patients the frequency (in hours) of doses may be obtained by multiplying the serum creatinine by 9. If azotemia or oliguria occur, discontinue therapy. Mycotic or bacterial superinfection may occur.

Adverse Reactions: Irritation or pain at the injection site, skin rash, drug fever, headache and paresthesias.

Dosage and Administration: The maximum total daily dose should not exceed 1.5 Gm. by all routes of administration. The usual dose is 7.5 mg./Kg./12 hours I.M. The average adult dose is 1 Gm. daily. Uncomplicated infections due to sensitive organisms should respond in 24 to 48 hours. If no response occurs in 3 to 5 days, stop therapy and recheck the bacterial sensitivities. Hydrate patients well to minimize renal irritation. Inject deeply into the upper outer quadrant of the gluteal muscle. Discard partially used vials after 48 hours. The drug should not be physically mixed with other antimicrobials.

Supplied: Rubber capped vials as a ready-to-use sterile aqueous solution in two concentrations: 0.5 Gm. in 2 ml. and 1.0 Gm. in 3 ml. Also available—Pediatric Injection 75 mg. in 2 ml. A.H.F.S. Category 8:12.28

BRISTOL
BRISTOL LABORATORIES
Division of Bristol-Myers Company, Syracuse, New York 13201

KANTREX® INJECTION
(kanamycin sulfate)

county societies

Oakland Society Asked To Compile Its History

The Oakland County Medical Society has been asked to contribute a brief history of its 139 years to the Oakland County Sesquicentennial *Book of History*. Otto O. Beck, M.D., Birmingham, former MSMS president who was active in the establishment of the William Beaumont, M.D., Memorial on Mackinac Island, has agreed to compile the Oakland history.

WCMS Amends Bylaws Concerning DO Members

On June 1 members of the Wayne County Medical Society amended their bylaws to conform with the Michigan State Medical Society's bylaws permitting the active membership of osteopathic physicians. Prior to the Wayne society members' vote, osteopathic physicians were eligible for associate membership in the society only.

Kalamazoo Academy Responds to CBS TV Series

Stimulated by the recent C.B.S. telecast series on "Health in America," the Kalamazoo Academy of Medicine passed a series of resolutions calling upon its board of directors to react to the many complaints that are being made concerning the delivery of medical care. Members of the Academy resolved to respond themselves to all charges and allegations which tend to discredit the medical profession, to determine the health care needs of Kalamazoo County, to develop imaginative, yet practical programs for the efficient use of available health personnel and facilities in Kalamazoo, and to make their views known to their legislators.

U-M SAMA President Writes Washtenaw Society

A letter published in the June issue of the Washtenaw County Medical Society *Bulletin* attempts to establish a new rapport between the members of the Student American Medical Association chapter at the University of Michigan and the Washtenaw society members. The letter is written by Jeffrey P. Callen, new president of the U. of M. SAMA chapter, and describes the major activities of his chapter. He intends to keep Washtenaw medical society members informed throughout the year of his chapter's activities.

Muskegon Physicians Sponsor Nurses' Course

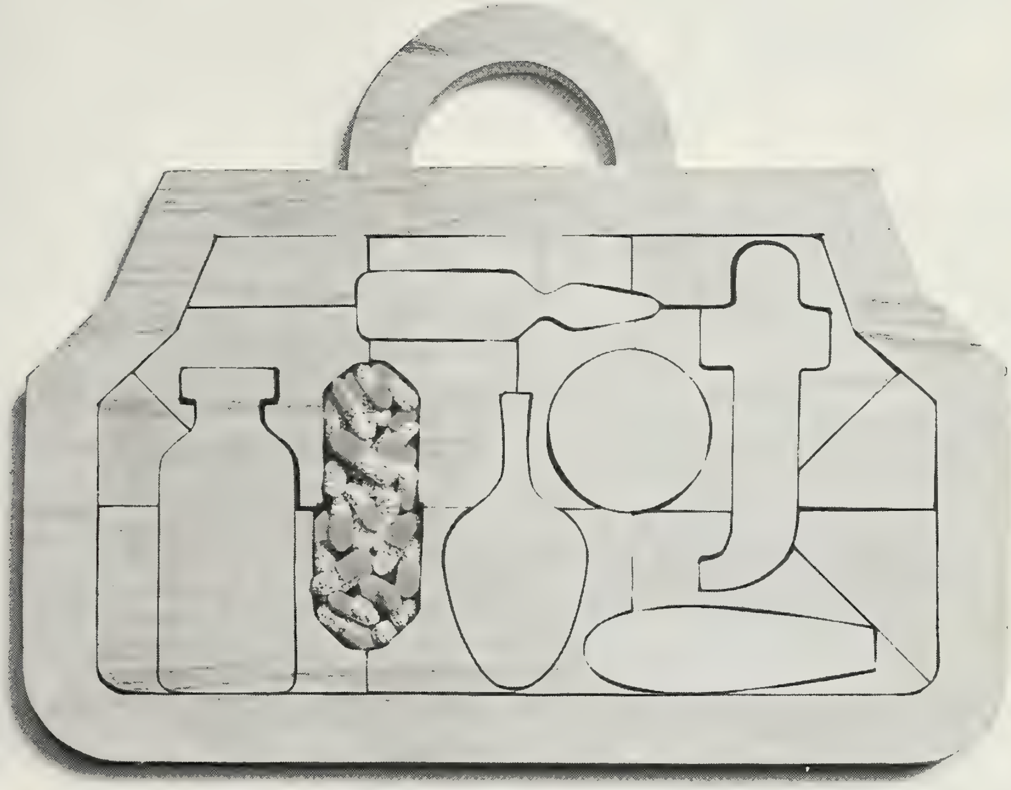
The Muskegon Medical Foundation of the Muskegon County Medical Society, in cooperation with the four area hospitals, made possible a 100-hour course in intensive coronary care for registered and licensed practical nurses recently.

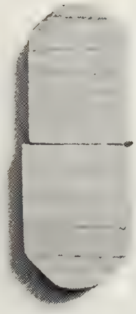
Ann Landers Addresses Kent County M.D.s

"Life is a grindstone. Whether it polishes us or grinds us to dust depends on what we're made of," nationally-syndicated columnist Ann Landers told the Kent County Medical Society in an appearance before them recently. Ann receives 370,000 letters a year and with 11 secretaries, answers every letter with a return address. She told her audience she had offered her body to Harvard Medical School upon her death — then facetiously added, "But some doctors want it now."

Doctor Whiteley Comments On Growth, Changes Of Wayne County Society

Robert K. Whiteley, M.D., Detroit, new president of the Wayne County Medical Society, observed in his inaugural speech recently, "The Wayne County Medical Society . . . has gone through several embryological gyrations, from a scientific society to a socio-economic political body. We are coming to be a part of the community as a whole. No longer can we be or are we an isolated group. This is good, not only for the society, but for the community."





One of seven dosage forms

Thorazine®

brand of chlorpromazine HCl

Spansule®

brand of sustained release capsules

Available in 30 mg., 75 mg., 150 mg., 200 mg. and 300 mg. strengths.

Smith Kline & French Laboratories
Philadelphia, Pa. 19101

Now
available for your
prescribing
needs

Cordran® Tape
Flurandrenolide Tape (4 mcg. per sq. cm.)

Additional information available upon request • Eli Lilly and Company, Indianapolis, Indiana 46206
000121

Lilly

Chronic Granulomatous Disease of Childhood

By Gerald Light, M.D.
Roman Knoblich, M.D.
Flint

Chronic granulomatous disease, a fatal disorder of childhood, is characterized by an increased susceptibility to infection manifested by chronic eczematoid dermatitis, granulomatous pneumonitis, hepatosplenomegaly and chronic suppurative lymphadenitis. The disease is due to an inherited defect of leukocyte function derived from, or coincident with, a deficiency of reduced nicotine adenine dinucleotid oxidase in the glycolytic system.

In this report one additional case of chronic granulomatous disease of childhood (CGD) is presented followed by a discussion based on a review of the current literature.

Case Report

M. K., a nine year old white boy, was admitted to the hospital with a two month history of right pleuritic pain unresponsive to antibiotic therapy. On the day of admission, he became clinically jaundiced and his oral temperature spiked to 104 degrees Fahrenheit.

His past history included repeated upper respiratory infections, two episodes of pneumonitis, and incision and drainage of sterile cervical abcesses on two occasions.

PHYSICAL EXAMINATION revealed a pale febrile patient who appeared chronically ill. The pulse was 120 per minute and the blood was 90/60 mm. Hg. The patient measured 54 inches and weighed 47 pounds. His skin and sclerae were icteric. Generalized lymphadenopathy was present. The lymph nodes were tender and mobile and measured up to 2 cm. in diameter. The rest of the physical examination was within normal limits.

The patient's total serum bilirubin was 12 mg/100 ml. Coagulase positive Staphylococcus aureus was cultured from the blood. He was treated with methicillin and penicillin intravenously. His jaundice cleared within one week. His oral temperature continued to spike up to 102 degrees.

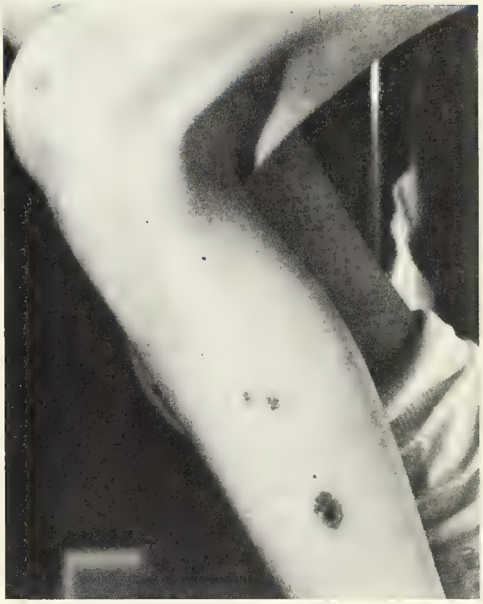


Fig. I. Maculopapular generalized skin eruptions. Some covered by scaly waxy eschars.

Three weeks after admission, a laparotomy was done. A sterile abscess of the falciform ligament and firm dark nodules on the liver surface were found. Biopsies of these nodules showed chronic granulomatous inflammation and fibrosis.

Postoperatively the patient developed a generalized maculopapular skin rash with vesicle formation and scaly waxy eschars (**Fig. I**). The rash disappeared after one month. Six weeks after ad-

scientific papers

Doctor Light is with the Mott Children's Health Center, Flint, and Doctor Knoblich is with the Department of Pathology at Hurley Hospital, Flint.

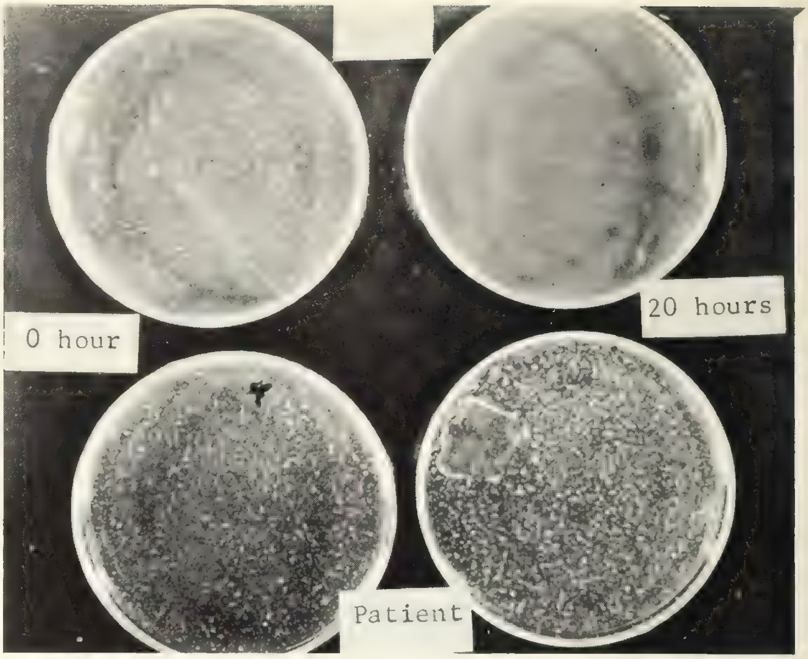


Fig. II. On the left, heavy growth is noted in the plated agar from bacteria-leukocyte mixture from control and patient, on the right, one sees complete cessation of growth of bacteria in the control plate and heavy persistent growth of bacteria in the plate representing the patient's bacteria-leukocyte mixture.

mission the patient became afebrile and his general condition improved markedly. Laboratory investigation at that time revealed normal urinalysis, blood sugar, SGOT, alkaline phosphatase, serum bilirubin, and negative fungal, viral, and bacteriological cultures from the skin, blood and bone marrow. A BSP excretion test showed 11 per cent retention after 45 minutes and an LDH isogram showed elevation of fraction V. The total serum protein was 7.6 gm/100 ml. with 35.2 per cent albumin and 30 per cent gamma globulin. An immune diffusion showed an IgG of 1920, and an IgM of 88 and an IgA of 450 mg/100 ml. A chest X-ray showed a calcified nodule in the right lung field without evidence of active pulmonary parenchymal disease.

THE HEMOGLOBIN ranged from 10 to 11 gm/100 ml. The WBC was 14,000 per cubic millimeter with 68 per cent segmented polymorphonuclear leukocytes. A bone marrow aspiration revealed normal elements.

The patient's leukocytes were tested for their *in vitro* bactericidal capacity using the method described by Quie, et al.[1]

Preparation of Standard Staphylococcus Aureus Culture

Broth cultures of coagulase positive staphylococcus are incubated, centrifuged, washed and suspended in 10% human serum in Hank's solution.

Preparation of Leukocyte Rich Substance

From 20 cc of heparinized patient and control blood the leukocyte rich buffy coat is separated by means of centrifugation. The leukocyte rich preparation is suspended in 10% human serum in Hank's solution.

Mixtures of the leukocyte rich preparation and the standard staphylococcus aureus cultures are incubated for a specific length of time and plated with nutrient agar into sterile Petri dishes at 37°C. The number of staphylococcal colonies are counted. The time of the plating with agar is designated 0 hour.

Peripheral white blood cells of patients suffering from CGD are unable to efficiently kill certain stains of ingested bacteria *in vitro*. The number of viable bacteria at 1½ and 3 hours following incubation with leukocyte rich suspension from patients with CGD are compared with the number of viable bacteria following incubation with leukocyte rich suspension from normal controls. **Figure II** shows bacteriologic culture plates inoculated with leukocyte rich preparations and measured viable staphylococcus aureus cultures. At zero hour heavy growth is seen in the agar plated from a mixture of bacteria and leukocyte rich preparation.

AT 20 HOURS the plate representing the normal person shows a complete cessation of growth of bacteria, whereas the plate representing the patient suffering from CGD shows a persistence of bacterial growth signifying the inability of the patient's leukocytes to effectively destroy the bacteria.

One year after the diagnosis had been established the patient was suffering from chronic hepatic stomatitis and recurrent multisystem infections. Under symptomatic care and treatment the patient's condition has not improved and the prognosis is grave, most likely fatal.

Discussion

Clinical Findings

Chronic granulomatous disease (CGD) of childhood is a fatal disorder characterized by increased susceptibility to infection which begins during the first year of life.[2] In addition to chronic suppurative lymphadenitis, hepatosplenomegaly, skin rash, and chronic granulomatous pneumonitis, other manifestations include enteritis, cheilosis, keratitis, blepharoconjunctivitis, meningitis, otitis media, symptomatic thymic enlargement, osteomyelitis, peritonitis and empyema.

Usually lymphadenopathy is the initial manifestation and as a rule begins before the age of two years. Although cervical lymphadenopathy may be most prominent, generalized lymphadenopathy with suppuration is usually present. Varying degrees of hepatomegaly are noted in all cases. Splenomegaly is usually present. The degree of hepatosplenomegaly may range from insignificant to massive enlargement. The characteristic dermatitis present about the eyes, nose and mouth is of seborrheic nature in its mildest form but often becomes eczematoid and frequently secondarily infected. The pulmonary signs and symptoms develop insidiously and are usually preceded by radiologic evidence of lung involvement. Pulmonary infiltrates involve different segments of the lung with occasional clearing of some segments. Pulmonary involvement becomes severe in the late stages of the illness.

Laboratory Findings

Laboratory findings include the above described defect of leukocyte function, hypochromic microcytic and sometimes normochromic normocytic anemia, elevated sedimentation rate and hypergammaglobulinemia, the latter a constant feature of the disease. These abnormalities are usually marked during active infection periods of the disease. Serum isohemagglutinin levels are normal and the ability to form circulating antibodies to one or more antigens is normal. The microorganisms demonstrated in the suppurative skin or visceral lesions are of low virulence. Cultures obtained from lesions early in the disease usually yield staphylococci or a variety of enteric bacteria. Attempts to isolate viruses have been uniformly unsuccessful.

There is no evidence that tuberculosis plays an etiologic role although positive skin tests to tuberculin, histoplasmin and coccidioidin have occasionally been reported. Three cases of systemic mycosis have been reported in patients with CGD.[3] Blastomycin, brucellergen, cat-scratch, Frei and Kveim skin tests have been frequently reported as negative. Polymorphonuclear leukocyte migration studied by the skin window technique modified by Rebuck and Crawley[4] has been shown to progress normally.[5] Urine analysis is normal in patients suffering from CGD, unless pyelonephritis complicates the clinical picture.

Pathology

The pathologic changes in CGD show chronic granulomatous inflammation involving multiple systems. Diffuse involvement of the skin, lungs, liver, spleen, lymph nodes and bone marrow is frequently seen. The thyroid and kidney may also be involved diffusely. Chronic pleuritis, enteritis, myocarditis, encephalitis and meningitis are frequently seen. Suppuration and abscess formation occur with moderate frequency and present themselves in the form of perinephric and subdiaphragmatic abscesses or empyema. In the multiple visceral granulomata microscopically one observes a basically similar pattern of response with minor variations. The chronic inflammatory response is characterized by a lymphocytic-plasmocytic infiltration. The granulomatous lesions may appear solid or sarcoid-like or may show liquefaction centers. Pigmented lipid histiocytes of unknown origin and significance are demonstrable in the reticular endothelial organs in nearly all cases. These lipid histiocytes are conspicuously absent from the lungs and bone marrow however. The granulomatous inflammation affecting the liver frequently leads to a periportal reaction which occasionally progresses to an early nodular cirrhosis.

Genetics

Genetic transmission as a sex-linked recessive trait has been postulated in chronic granulomatous disease.[6] Female relatives have been shown to have intermediate defects in granulocyte function when compared with normal controls and with patients with CGD.[7]

Etiology

It has been repeatedly shown that leukocytes from patients with CGD are able to ingest but not destroy Staphylococcus aureus, Paracolon hafnia, Aerobacter aerogenes, vaccinia, and herpes simplex viruses.[1, 8] It has been shown that these defective leukocytes in contrast to normal leukocytes do not exhibit an increase in oxygen consumption during phagocytosis,[9] nor do they possess the activity of an enxyme necessary for the reduction of nitroblue tetrazolium dye.[10, 11] The failure to reduce nitroblue tetrazolium is due to defective operation of an oxidase of reduced nicotinamide adenine dinucleotide that directly stimulates the oxidation of glucose -6-phosphate in leukocytes.

In CGD lack of leukocyte degranulation following phagocytosis[8, 9] suggests the persistence of intact lysosomes. Hydrolases released during lysosomal destruction are essential for degradation of cell wall material of micro-organisms coated with antibody and complement. The lack of degranulation may be due to an impaired glycolytic system as a result of deficient nicotinamide adenine dinucleotide activity.

The abnormal intraleukocyte survival of bacteria may provide an explanation for the development of granulomata in reticuloendothelial tissues. Since viable intramonocytic organisms are associated with granulomatous processes, the occurrence of similar lesions in CGD suggests that abnormal leukocyte function can provide a granulomatous adaptation. Analogously, the development of a cellular immune reaction may account for the formation of granulomata.

Response to Treatment

Antibiotic therapy has been successful during acute episodes of infections[3] but their prophylactic use does not influence the course of the disease. Treatment with gamma globulins, buffy coat infusions, corticosteroids, progesterones and antifungal or antituberculous agents have been unrewarding.[3] After the onset of symptoms most patients exhibit growth failure. The course in some cases of CGD is characterized by remissions[12] always followed by recurrent infections which most often lead to death during school age.

"Box Summary"

The authors present one additional case of chronic granulomatous disease of childhood. This fatal disorder of childhood is discussed from the diagnostic, etiologic and therapeutic viewpoint. This disease should be considered in male children who suffer from repeated infections of skin, lung and lymph nodes.

References

1. Quie, P. G., White, J. G., Holmes, B., and Good, R. A.: *In vitro* bactericidal capacity of human polymorphonuclear leukocytes: Diminished activity in chronic granulomatous disease of childhood, J Clin Invest 46:668-679, 1967.
2. Berendes, H., Bridges, R. A., and Good, R. A.: A Fatal Granulomatosis of Childhood, Minn Med 40:309-312, 1957.
3. Carson, M. J., Chadwick, D. L., Brubaker, C. A., Cleland, R. S., and Landing, B. H.: Thirteen boys with progressive septic granulomatosis, Ped 35:405-412, 1965.
4. Rebuck, J. W., and Crawley, J. H.: A method of studying leukocyte functions *in vivo,* Ann N Y Acad Sci 59:757-805, 1955.
5. Holmes, B., Quie, P. G., Windhorst, D. B., and Good, R. A.: Fatal Granulomatous disease of childhood, Lancet 1:1225-1231, 1966.
6. Blattner, R. J.: Chronic Granulomatous Disease, Journ Pediat 74:315-318, 1969.
7. Windhorst, D. B., Holmes, B., and Good, R. A.: A newly defined x-linked trait in man with demonstration of the Lyon effect in carrier females, Lancet 1:737-739, 1967.
8. MacFarlane, P. S., Speirs, A. L., and Somnerville, R. G.: Fatal granulomatous disease of childhood and benign lymphocytic infiltration of the skin (Congenital Dysphagocytosis), Lancet 1:408-410, 1967.
9. Holmes, B., Page, A. R., and Good, R. A.: Studies of metabolic activity of leukocytes from patients with genetic abnormality of phagocytic function, J Clin Invest 46:1422-32, 1967.
10. Baehner, R. L., and Nathan, D. G.: Quantitative nibroblue tetrazolium test in chronic granulomatous disease, New England J Med 278:971-976, 1968.
11. Baehner, R. L., and Nathan, D. G.: Leukocyte Oxidase: Defective activity in chronic granulomatous disease, Science 155:835-836, 1967.
12. Anderson, V., Koch, C., Vejlsgaard, R., and Wilken, Jensen J.: Fatal granulomatous disease, Acta Pediat Scand 57:110-114, 1968.

Prosthetic Replacement Of the Mitral Valve

An Assessment of the Clinical And Hemodynamic Results of Operation

By Andrew G. Morrow, M.D.
Bethesda, Md.

The Starr-Edwards prosthetic mitral valve has provided the surgeon a means for correcting malformations of the mitral valve that are not otherwise amenable to operative treatment.

These malformations may be generally classified as rheumatic mitral regurgitation and calcific mitral stenosis, although, rarely, valve replacement is required in a patient with congenital heart disease. In many other patients with pure or predominant mitral stenosis, the valve may retain reasonable mobility and remain free or nearly free of calcification.

In such patients, who are usually young women in regular sinus rhythm, relief of obstruction can be achieved by digital or instrumental mitral commissurotomy, and this safe and simple closed operation should be applied whenever possible.

In contrast, when a stenotic valve and the supporting subvalvular structures are heavily calcified and densely fibrotic, effective function can almost never be restored, even by debridement and commissurotomy under direct vision. In this clinic the results of reconstructive operations for mitral regurgitation have also been poor; moderate to severe regurgitation has recurred in virtually all patients after 1-2 years, even though the valve was competent in the early postoperative period.

The Starr-Edwards prosthesis has been utilized at the National Heart Institute since 1961, and has been inserted in more than 300 patients. Recently, the early and late results of operative treatment in 100 consecutive patients were reviewed, and these are summarized in the present report.

The Patients

The 100 patients all had acquired mitral valve disease, and two-thirds gave a clear history of previous rheumatic fever. Fifty-three were female, 47 were male, and they ranged in age from 10 to 64 years; the mean age at operation was 38 years. All patients were distinctly symptomatic, and 34 were in Class IV (NYHA), 64 in Class III, and 2 in Class II. Hospitalization for the treatment of congestive heart failure had been necessary on one or more occasions in 87 patients, and 38 had been hospitalized 3 or more times. Previous operations on the mitral valve had been performed in 35 patients.

The characteristic clinical, radiographic, and electrocardiographic findings of mitral stenosis, mitral regurgitation or a combined mitral valvular malformation were evident in each patient. In 36 patients signs of tricuspid regurgitation were also present, and 24 patients had physical evidence of aortic regurgitation, but of insufficient severity to necessitate aortic valve replacement. Calcification of the mitral valve was evident fluoroscopically in 63 patients.

All of the patients were studied by right and 95 by left heart catheterization preoperatively. On the basis of the preoperative hemodynamic and angiographic assessments and the operative findings, 50 patients were considered to have pure or predominant mitral stenosis, and 50 to have pure or predominant mitral regurgitation. In the entire group of 100 severe pulmonary hypertension (systolic $=$ 50 mm. Hg) was present in 69 patients, and the average cardiac index was reduced to 2.1 L./min./M^2. Preoperatively, the left atrial mean pressure was abnormally elevated in 96 patients (average 22 mm. Hg); a diastolic gradient across the valve was recorded in all patients with mitral stenosis and in 33 of those with mitral regurgitation.

The author is chief of the Clinic of Surgery at the National Heart Institute in Bethesda, Md. His paper is another in the series on clinical cardiology prepared by the American Heart Association and made available to **Michigan Medicine** by the Michigan Heart Association.

The Operation

In most patients the operation was performed through a left lateral thoracotomy (with right ventricular cannulation for venous return), and in the remainder a median sternotomy or right thoracotomy was employed. Cardiopulmonary bypass was usually conducted at 37°C., but mild (30°C.) general hypothermia was induced when aortic regurgitation necessitated numerous or prolonged periods of aortic occlusion. Ventricular fibrillation was induced in most patients by A.C. stimulation.

When the necessity of valve replacement had been determined, the valve was excised in continuity with the chordae tendineae and papillary muscles. Residual calcific deposits in the annulus were removed with a rongeur, and the ventricle was lavaged. The prosthetic valves employed were those supplied by the Edwards Laboratories at the time, and all had bare metal orifices and struts and silastic poppets. Size 3M or 4M valves were inserted in 90 patients, while nine received 2M valves, and one a 5M. The valves were anchored by 15-20 interrupted sutures, each passed twice through the fixation ring of the prosthesis and the patient's valve ring. In 17 patients a left atrial thrombus was present, and was excised prior to valve replacement; in six of these calcification of the left atrial wall was evident preoperatively.

In the immediate postoperative period assisted ventilation was provided via the endotracheal tube for 12-24 hours, and in 34 patients longer periods of assistance required tracheostomy. Anticoagulation with warfarin was instituted 48-72 hours after operation.

The Results

Immediate Mortality: Seventeen (17%) of the 100 patients died during the hospital admission at which valve replacement was carried out. Two patients died in the operating room; one had uncontrolled bleeding from the atrium, and in the other effective cardiac contractions could not be restored after bypass. Eight patients died one to seven days after operation with progressive hypotension and signs of reduced cardiac output; all had normal or small left ventricular cavities. At necropsy it appeared that obstruction to left atrial outflow had been produced by incomplete descent of the prosthetic ball that, in turn, resulted from protrusion of the muscular ventricular septum into the cage. In five of the eight patients massive thrombosis of the valve and atrium had occurred. Two other patients died of acute myocardial infarction, one the result of a coronary arterial embolus. One patient died of cerebral embolism from air trapped in the atrial appendage, and another from infected pulmonary emboli which had been present preoperatively. The remaining three patients, all young women with mitral regurgitation, died one or two days postoperatively after evidencing cardiac failure and hypotension; no anatomic cause of death was evident at necropsy.

Late Mortality: Seven of the 83 patients who survived the immediate postoperative period have died 5 to 24 months later. Two had infectious endocarditis; in one patient the infection followed an intercurrent operation performed without the administration of antibiotics. One patient sustained a fatal cerebral embolus after her physician had stopped warfarin administration for unknown reasons. Another patient had a subarachnoid hemorrhage as a result of warfarin overdosage. One patient died in heart failure after an unsuccessful attempt to close a peribasilar fistula. In the remaining 2 patients death was sudden and unexpected and the cause is unknown.

Thromboembolism and Anticoagulation: An attempt has been made to maintain all patients on therapeutic doses of warfarin, but this aspect of the patient's management has been under the control of the referring physicians. Nine patients have sustained definite cerebral emboli, and in two of these cerebral embolism occurred on two different occasions. As noted above, one of the patients with cerebral embolism, who was not receiving warfarin, died. Another has persistent flaccid hemiparesis and is severely incapacitated. Two patients have neurologic abnormalities on examination, but they are asymptomatic. The other five patients who had cerebral emboli have no detectable abnormal findings. Five additional patients have described transient vertigo, amnesia, or muscular weakness, but in them no neurologic abnormalities have ever been detected on any examination.

One patient died as the result of warfarin toxicity, and two others have had massive but nonfatal episodes of gastrointestinal bleeding.

Clinical Status: The 76 surviving patients have been followed for intervals of two to six years. Forty-seven of them (62%) are asymptomatic (Class I), 26 are in functional Class II, and 3 are in Class III. Preoperatively, 52 of these 76 patients were in Class III, and 23 were in Class IV. Fifty-three patients (70%) are working full-time or, in the case of some women, managing their homes and families without unusual assistance. Sixty-nine patients (92%) are on unrestricted diets.

Postoperative Hemodynamic Assessments: The resting pulmonary arterial pressure was lower postoperatively in every patient in whom it was abnormally elevated before operation, and the systolic pressure was less than 50 mm. Hg in 71 of 74 patients studied. The left atrial mean pressure was also reduced in every patient in whom it had been abnormal, but in 15 of 68 patients it still exceeded 12 mm. Hg. The cardiac index was higher postoperatively in 63 of 67 patients, and the average postoperative value was normal, 2.9 L./min./M.².

Some Conclusions Concerning Mitral Valve Replacement

The experience with mitral valve replacement in these and other patients allows certain conclusions concerning the present status of the operation, and permits some predictions as to its future applicability. The immediate operative risk continues to approximate 10%, and will probably not become significantly lower as long as the operation is reserved for severely ill patients, those in classes III and IV. The Starr-Edwards prosthesis is the subject of constant re-evaluation and improvement, and as the long-term reliability of the valve improves, operation reasonably can and should be recommended to patients earlier in the course of their disease. The incidence of death and disabling complications in the late postoperative period has thus far been distinctly lower than in patients with prosthetic aortic valves. Arterial emboli have occurred in about one-fifth of patients, in spite of attempts to maintain effective anticoagulation with warfarin, but significant sequelae of the emboli have been absent or inconsequential except in two patients. Improved prostheses can be expected to eliminate or greatly reduce the incidence of thromboembolism. Of greatest importance is the fact that surviving patients have experienced striking and sometimes dramatic symptomatic improvement, and almost all have been able to return to useful and productive lives and to carry on their increased activities without significant discomfort. The postoperative hemodynamic studies have shown that symptomatic improvement is paralleled by a return of the cardiac output and intracardiac pressures to normal or near-normal levels.

Michigan
State
Medical
Society
1866

INFORMATION FOR CONTRIBUTORS

1. Address scientific manuscripts to the Publication Committee, Michigan State Medical Society, 120 West Saginaw Street, East Lansing, Michigan 48823.

2. Submit original, double-spaced typewritten copy and two carbon copies or photo copies on letter size (8½ x 11 inch) paper.

3. On page one, include title, authors, degrees, academic titles, and any institutional or other credits.

4. Authors are responsible for all statements, methods, and conclusions. These may or may not be in harmony with the views of the Editorial Staff. It is hoped that authors may have as wide a latitude as space available and general policy will permit. The Publication Committee expressly reserves the right to alter or reject any manuscript, or any contribution, whether solicited or not.

5. Illustrations should be submitted in the form of glossy prints or original sketches from which reproductions will be made by **Michigan Medicine.**

6. Contributors will be notified as soon as practical if a manuscript is accepted for publication. Unused manuscripts will be returned. Every care will be taken with the submitted material but the Journal will not hold itself responsible for loss or damage to manuscripts.

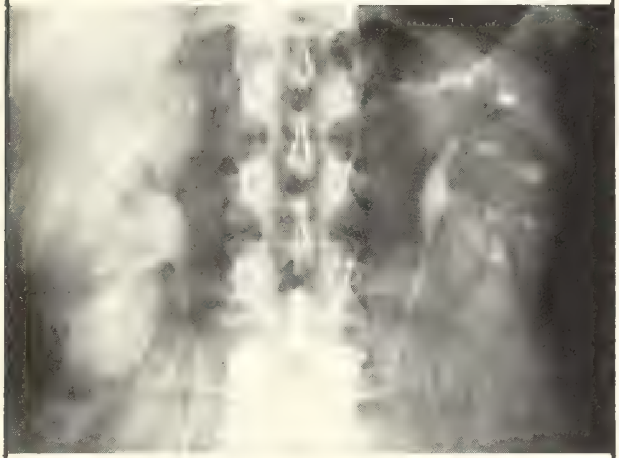
7. Articles should ordinarily be less than four printed pages in length (3000 words).

8. References should conform to *Cumulative Index Medicus,* including, in order: Author, title, journal, volume number, page, and year. Book references should include editors, edition, publisher, and place of publication, as well.

9. Specify address to which galley proofs should be sent. Proofs will be mailed to authors for correction before publication and should be returned to the editor in 48 hours. If proofs approved by the author are not received by the editor prior to deadline, publication of the article will be cancelled for that issue.

10. The editors welcome, and will consider for publication, letters containing information of interest to Michigan physicians, or presenting constructive comment on current controversial issues. News items and notes are welcome.

11. It is understood that material is submitted for exclusive publication in **Michigan Medicine.**



The Viewbox

By Raymond S. Kurtzman, M.D.
Associate Scientific Editor

Diagnosis

Renal Papillary Necrosis (caused by excessive use of analgesics).

X-ray Findings

There is destruction of the tips of the renal papillae, as visualized by excretory urography. Occasionally necrotic renal tissue can calcify.

Discussion

Renal papillary necrosis is found in a number of conditions, including infection, particularly with diabetes, sickle cell anemia, and as the result of drug toxicity. Phenacetin (the "P" in APC) is particularly likely to produce renal damage when taken in excess. A number of proprietary analgesics contain phenacetin, and these drugs are consumed by the ton in our country, in which everyone seems to have headaches. The patient whose X-ray is presented had taken at least 6 tablets per day of a popular phenacetin containing analgesic for at least three years.

Symptoms of renal papillary necrosis include flank pain and hematuria. Occasionally, renal tissue is passed and the diagnosis can be established histologically.

The radiological differential diagnosis includes medullary sponge kidney, a congenital lesion, in which the renal tubules are dilated and cyst-like, and can contain calculi, and chronic pyelonephritis.

References

Prescott, L. F.:
Analgesic abuse and Renal Disease in Northeast Scotland. *The Lancet*: 7474, p 1143. 26 Nov., 1966.

New Edition Of Terminology Guide Available

Now available is a greatly expanded second edition of *Current Procedural Terminology,* first published in 1966 in response to the need for a dictionary of standard terms and codes for diagnostic and therapeutic procedures. The original four-digit coding has been translated into a five-digit system that is less restrictive. Many changes and additions are incorporated in the new edition. Copies, $2 each, may be obtained from Order Dept., AMA Headquarters. Complimentary copies are being sent to executive secretaries of state and county medical societies.

(*Taken from AMA Newsletter, Volume 2, Number 14, April 6, 1970*)

Fellowships Awarded MSU To Study Cancer-Inhibiting Platinum Chemicals

Two of the nation's largest platinum companies have set up research fellowships at Michigan State University to support research on platinum chemicals, the first such metallic chemicals found to have tumor-inhibiting qualities.

The Matthey Bishop Cancer Research Fellowship Fund and the Englehard Industries Cancer Research Fellowship Fund both began early this year. MSU biophysicist Barnett Rosenberg, Ph.D., will direct the antitumor research under both fellowships, which will provide total support of $70,000 per year.

Morphological Alterations Of Red Cells

An Important Clue in the Diagnosis and Treatment Of Intravascular Hemolytic Processes

By N. A. Nelson, M.D.
M. A. Khan, M.D.
G. A. Stair, M.D.
D. H. Woodbury, M.D.
L. Kole, M.D.
T. Meadows, M.D.
All of Eloise

The term "microangiopathic hemolytic anemia" was originally used by Symmers in 1952,[1] but it was not until 1962 that Dacie and Brain[2] emphasized the relationship of small blood vessel disease (microangiopathy) and intravascular hemolysis with characteristic red blood cell changes; i.e., schistocytes, burr cells, and helmet cells (**Fig. 1**). Thrombocytopenia is an associated finding in this syndrome.

It is our observation in 10 cases (**Table 1**) that these morphologic changes occur in diverse clinical conditions. In the brief period of four months, nine cases were seen in the Hematology Laboratories of Wayne County General Hospital which demonstrated characteristic red blood cell changes. These included two cases of prosthetic cardiac valve replacement[3, 4, 5], one each of SLE, scleroderma, preeclampsia with dead fetus, consumptive coagulopathy, disseminated carcinoma, clostridial sepsis following criminal abortion, thrombotic thrombocytopenic purpura, and malignant hypertension.

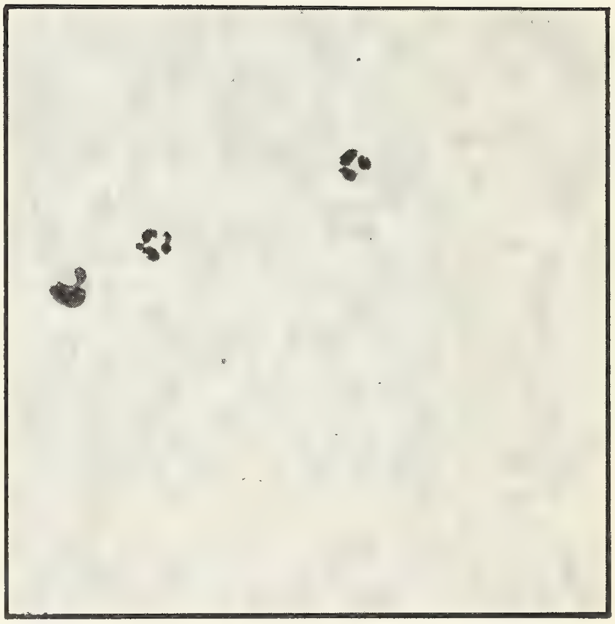


Figure 1: Peripheral blood smear from Case M.M. showing fragmented red blood cells

Summary of Cases

Case M.M. This 32-year-old white female underwent valvuloplasty on December 10, 1968. The patient remained on the cardiac bypass for 29 minutes. That evening one litre of clotted blood was removed from the thoracic cavity. Following this, she gradually developed widespread purpuric and ecchymotic lesions. These were especially pronounced over her legs and at injection sites. Her lower extremities were cold with very feeble dor-

---

Doctor Nelson is chief, Hematology Service, Department of Medicine, Wayne County General Hospital, and Doctor Khan, Doctor Stair and Doctor Kole are members of his staff. Doctor Woodbury is chief of the Department of Radioisotopes, Wayne County General Hospital and Doctor Meadows is a staff member, Department of Pathology, Wayne County General Hospital. Doctor Nelson, Doctor Stair, Doctor Woodbury and Doctor Meadows are also members of the faculty at the University of Michigan.

TABLE 1. SUMMARY OF CASES

No.	Case	Age	Sex	Diagnosis	B.P. mm Hg.	BUN	Hct. %	Retic. %	Platelets $1000/mm^3$	Partial Thromboplastin Time (PTT)	Fibrinogen mg %	RBC Morph. 0-4*	Lactic Acid Dehydrogenase	Bone Marrow	**Response to Heparin Therapy
1	MM	32	F	Consumptive coagulopathy	120/70	110	35		32	50	299	3+			4+
2	DW	35	F	Pre-eclampsia	160/90	63	25	11.8	140			4+		Erythroid hyperplasia	4+
3	EG	32	F	S. L. E.	170/110	159	16	10.8	40			3+	increased	Erythroid hyperplasia	0
4	LW	20	F	Clostridial sepsis	80/50	37	26		12	90	550	2+			-
5	RB	35	M	Malignant hypertension	220/138	96	25	6.4	22	42	700	4+	increased	Erythroid hyperplasia	±
6	TB	29	M	Cardiac Prosthesis	100/50	9	36	9.2	435		400	4+		Erythroid hyperplasia	0
7	MN	43	F	Cardiac Prosthesis	132/60	12	16	13.1	200			4+	increased	Erythroid hyperplasia	0
8	RM	53	F	Disseminated Ca	100/60	18	17	5	3			3+		Erythroid hyperplasia	0
9	PS	29	F	Scleroderma	172/96	82	24	14.6	85		450	3+	increased	Erythroid hyperplasia	-
10	LC	50	F	Thrombotic thrombocytopenic purpura	118/74	77	25	2.8	Decreased			4+	increased		0

* 0 Normal
4 Marked Fragmentation
** 4 Excellent Response
0 Not tried
± Questionable Response
_ No Response

salis pedis artery pulsations bilaterally. Early gangrenous changes of the toes were present. Her blood pressure was 120/70 mm. Mercury, pulse 110/minute, respirations 20/minute, and temperature 98.4 F. On December 5th, prior to surgery, her hematocrit had been 46%, white count 6100 cu.mm., platelets 185,000/cu.mm., prothrombin time 100%, PTT 40 seconds, fibrinogen level 375 mg.%, BUN 18 mg.%, creatinine 0.8 mg.%. On the ninth postoperative day, her hematocrit had fallen to 28.5%, white count rose to 23,900/cu. mm. (PMN's 87%, lymphocytes 6%, eosinophils 2%, myelocytes 2%, and metamyelocytes 3%), her platelets were 32,500/cu.mm., prothrombin time 56%, PTT 50 seconds (normal control 40 seconds), fibrinogen level 299 mg.%, BUN 100 mg.%.

The peripheral blood smear revealed marked fragmentation and distortion of red cells including the presence of helmet cells, burr cells, and schistocytes. There were 14 nucleated red blood cells/100 white blood cells. The direct and indirect Coombs' tests were negative. She was taking Digitoxin and Quinidine, which were continued, and she was also receiving intravenous sodium cephalothin (Keflin) for a right lower lobe pneumonitis.

On December 18th, 5,000 units of aqueous heparin intravenously every 6 hours was started. She also received 3 units of packed red blood cells. A marked decrease in fragmented erythrocytes was noted after heparin therapy and, within the week, the platelet count and BUN had returned to normal (245,000 and 15 mg.% respectively). Subsequently, she underwent BK amputations because of gangrene of the feet. Histologic sections revealed extensive thromboemboli of the larger vessels with extensive necrosis of the skin.

Case R.B. This 36-year-old Negro was transferred from a local hospital because of azotemia, anemia, and "hemoglobinuria." Physical examination revealed a lethargic, well-developed male. His blood pressure was 220/128 mm. Mercury, pulse 84/minute, and respirations 20/minute. Funduscopic examination revealed cotton-wool and hard exudates. His hematocrit was 25%, reticulocytes 6.4%, white blood cells 7,150 cu.mm., BUN 96, creatinine 16.8, bilirubin 1.2 mg.%, platelets 22,000/cu. mm., LDH 1,080 with incresaed fractions 1 & 2. The plasma hemoglobin was 24 mg.% and bone marrow examination revealed erythroid hyperplasia. The prothrombin time, PTT, bleeding and clotting times were normal, and fibrinogen level was 700 mg.%. The peripheral blood smears revealed many burr cells, helmet cells, and schistocytes.

The patient was started on 7,500 units of aqueous heparin subcutaneously every 8 hours, but no significant improvement was noted and finally after also receiving steroids, he was started on the chronic hemodialysis program at Wayne County General Hospital. Because of uncontrolled hypertension, he underwent bilateral nephrectomy on November 18, 1968. His current blood pressure without any medication is 120/80. The peripheral blood smears show less striking changes, although his hematocrit remains low at 25% with reticulocyte count of 1%. Histologic sections of the kidneys revealed marked intimal thickening and narrowing of the lumina of arteries and arterioles with focal fibrinoid necrosis and intimal hemorrhages, and complete occlusion of some vessels within the glomeruli, all compatible with accelerated or malignant hypertension.

Discussion

Our study includes 10 cases (**see Table 1**), nine of which were seen within a four-month period of time. Three of these cases (i.e., scleroderma, consumptive coagulopathy, and clostridial sepsis) represent rarely reported cases of red cell fragmentation and intravascular hemolysis.

Careful examination of stained blood films was of paramount importance in detecting the characteristic erythrocyte changes. In some cases, the underlying disorder was diagnosed and treated early with the help of these morphologic changes and other laboratory findings.

Baker, et al,[6] using I-131 labeled fibrinogen, have shown fibrinogen catabolism to be increased in microangiopathic hemolytic anemia. There is also experimental evidence of a relationship of defibrination to intravascular hemolysis. It is therefore quite justifiable to administer heparin early in these cases to avoid serious complications. In fact, early institution of heparin may be life saving. Routine hematological and coagulation studies are of further help. Fibrinogen levels were normal when done and hence undue emphasis should not be placed on the presence or absence of hypofibrinogenemia.

In conclusion, we wish to stress that striking morphologic alterations of the red blood cells occur frequently. Invaluable information may be obtained by careful examination of the blood smear. Heparin therapy should be instituted early if there is evidence of concomitant hemolysis and/or a consumptive coagulopathy.[7] Heparin therapy apparently has not been effective when the disease process has been progressive. It is, however, possible that heparin may arrest further progression of small blood vessel pathology and thus help salvage these patients before other therapeutic modalities can be instituted. The existence of a vicious circle of microangiopathic hemolytic anemia leading to defibrination or vice versa has been suggested by Baker, et al.[6] It is postulated that subacute defibrination without overt evidence of "microangiopathy" may produce the characteristic blood picture and it is at this stage that heparin therapy would be most beneficial.

References

1. Symmers, W. St. C. "Thrombotic Microangiopathic Hemolytic Anemia (Thrombotic Microangiopathy)." British Medical Journal 11:897, 1952.
2. Brain, M. C., Dacie, J. V., and Hourihane, D. O'B. "Microangiopathic Hemolytic Anemia: The Possible Role of Vascular Lesions in Pathogenesis." British Journal of Hematology 8:358, 1962.
3. Sayed, H. N., Dacie, J. V., Handley, D. A., Lewis, S. M., and Cleland, W. P. "Hemolytic Anemia of Mechanical Origin After Open Heart Surgery." Thorax 16:356, 1961.
4. Stevenson, T. D. and Baker, H. J. "Hemolytic Anemia Following Insertion of Starr-Edwards Valve Prosthesis." Lancet 2:982, 1964.
5. Rubinson, R. M., Morrow, A. G., and Gebel, P. "Mechanical Destruction of Erythrocytes by Incompetent Aortic Valvular Prosthesis: Clinical Hemodynamic and Hematologic Findings." American Heart Journal 71:179, 1966.
6. Baker, L.R.I., Rubenberg, M. L., Dacie, J. V., and Brain, M. C. "Fibrinogen Catabolism in Microangiopathic Hemolytic Anemia." British Journal of Hematology 14:617, 1968.
7. Brain, M. C., Baker, L. R. I., McBride, J. A., Rubenberg, M. L., and Dacie, J. V. "Treatment of Patients with Microangiopathic Hemolytic Anemia with Heparin." British Journal of Hematology 15:603, 1968.

Perinatal Tips

By Paul M. Zavell, M.D.
Detroit

The following case from the files of the Wayne County Medical Society Perinatal Mortality Committee is presented as an aid in continuing education.

Maternal

This was the second pregnancy of a 27 year old O+ black diabetic mother. Her first pregnancy ended with a live premature infant that subsequently died of respiratory distress. The mother's diabetes was well controlled during this pregnancy and she was seen monthly in an obstetrical clinic. At 37 weeks there was spontaneous rupture of membranes. Labor did not begin for another 18 hours and ended 23 hours, 44 minutes later with the birth of a 5 lb. 8 oz. living black female infant. Second stage was difficult due to a transverse lie needing obstetrical manipulation for vertex delivery.

Fetal

Thirty minutes after birth grunty and rapid respirations began. The infant was examined and the only finding was a "little paleness" despite being a black infant. A CBC revealed Hemoglobin of 11.0 gm, Hct of 30, WBC of 19,800 with 32 PMN, 5 Juveniles, 60 Lymphocytes, 3 Eosinophils. Blood sugar was 54 mgm%. Chest X-ray revealed "incomplete aeration of lungs with marked elevation of the right diaphragm."

The infant was placed in Oxygen and Mist in an isolette but respirations (40-60 per minute) became more rapid and shallow with increasing substernal retractions. The diagnosis of "respiratory distress syndrome" was made but it was not considered necessary to use the Usher Method at this time. The infant was reseen 6 hours later as her condition steadily worsened. At this time fine crackles in the lungs were noted with respirations now 80-100 times per minute. Also the liver was felt 3 fgb below the RCM. The Usher Method was started (sodium bicarbonate in I.V. fluid). Despite this the infant expired 2 hours later.

Post Mortem exam revealed "passive congestion of most tissues, mild fetal atelectasis (not widespread) and large subcapsulary enlargement of liver due to massive hematoma."

Perinatal Committee Comments and Tips

1. A Hemoglobulin of 11.0 gm in a newborn is distinctly low (normal *at least* 14.0 gm and usually higher). This should tip one off to possible bleeding or loss of blood and appropriate studies with possible transfusion should be considered.

2. With ruptured membranes longer than 24 hours the infant should be suspect as possibly infected. If respiratory symptoms or unusual symptoms develop (low or high temperature, poor feed, vomiting, etc.) sepsis should be suspected, infant investigated (blood, throat, umbilicus, etc., cultures) and antibiotics started until no infection proven.

3. If a mother has a prior loss (such as this case) and a complicated problem (here diabetes), consideration of early C-Section should be given when labor is poor or prolonged.

4. A chest X-ray with a markedly elevated right or left diaphragm in an infant with respiratory difficulties is not normal. Nor is it diagnostic of hyaline membrane or the respiratory distress syndrome (despite diabetic mother and premature infant). Other diagnoses (hematoma, diaphragmatic hernia, cystic lung disease, etc.) should be considered and evaluated properly.

Doctor Zavell is chairman, Neo-Natal and Hospital Care Committee, Michigan Chapter, A.A.P., and chairman, Perinatal Mortality Study Committee, Wayne County Medical Society.

For Pneumatosis Cystoides Intestinalis

Resection Of the Ascending Colon

By Z. Steiger, M.D.
N. M. Jackiw, M.D.
Walter H. Gerwig, Jr., M.D.
T. C. Knechtges, M.D.
All of Allen Park

Pneumatosis cystoides intestinalis is a rare disease and usually has a benign course. Resection of bowel is rarely indicated. This is a report of one case where resection of the right colon had to be done because of intermittent large bowel obstruction.

Koss[1] reviewing a series of 213 cases of pneumatosis cystoides intestinalis found most of them present in the small bowel and only 13 were located in the large bowel.

The etiology of pneumatosis cystoides intestinalis is unclear. Infection is considered as a causative factor and gas forming organisms in the mucosa are often incriminated.[2] The fact is that cysts are usually sterile and the character of the disease isn't that of an infectious process. Druckmann[3] pointed out the malnutrition in these individuals.

Several authors postulate that mechanical factors have a dominant role in the formation of the cysts. Among these are rupture of pulmonary alveoli from a variety of causes into the mediastinum and dissection of the free air into the retroperitoneum, mesentery and eventually the bowel wall.[4] Entrance of air into the bowel wall at the site of ulcerations was considered also as a possibility. Allergy, pulmonary fibrosis,[5] are also considered. The fact that the gas from the cysts is not absorbed is attributed to the fact that foreign connective tissue encapsulates them.[6]

Pathology

The cysts vary in size from .5 mm. to 10 cm. They are subserosal and submucosal. They are encapsulated by bands of connective tissue with places lined with endothelial cells and foreign body-type giant cells. The cysts are considered to be distended tissue spaces. Some authors consider such cysts to be dilated lymphatic vessels. No part of the GI tract is exempt from involvement. The most commonly involved regions are the terminal ileum, cecum and splenic flexure and descending colon.[7]

Clinical Features

Most patients are in their middle age. They have abdominal discomfort, constipation, diarrhea and intermittent obstruction. There is usually no justification for resection except when obstruction is present. In children, pneumatosis cystoides intestinalis is associated with severe entero-colitis. On X-ray, pneumatosis cystoides intestinalis is often diagnosed as a polypoid lesion.[8,9]

Case History

J. W., SS# 428 269 760, 53 year old Negro male was admitted to the Allen Park, Michigan VA Hospital on November 21, 1966. In his professional history the patient was a sandblaster and foundry worker. His chief complaint at time of admission was swelling of the abdomen with

---

Doctor Steiger is assistant professor of surgery, Doctor Jackiw is an instructor in the Department of Radiology, Doctor Gerwig is a former professor of surgery and former chief of surgery at Allen Park VA Hospital and Doctor Knechtges is an assistant professor of pathology. All are with Wayne State University and the Allen Park VA Hospital, except Doctor Gerwig, who is now chief of surgical education, Santa Barbara Cottage and General Hospitals, Santa Barbara, Calif.

intermittent cramping pain and nausea which had been present for the past three weeks. There was an associated shortness of breath on minimal activity.

In his past history, patient was found to have pulmonary tuberculosis in 1964 and was treated with INH and Streptomycin for eight months.

On physical examination the patient was found to be in congestive failure. His chest was hyperresonant on percussion. There were coarse rales posteriorly with decreased breath sounds. On palpation of the abdomen, a mass was palpable along the ascending colon. This was hyperresonant on percussion.

X-ray of the chest showed infiltration of the upper lung fields with rarefactions representing cavities. There were granular densities in both lungs suggestive of silicosis. The patient was treated with digitalis and hydrodiuril. **Fig. 1.**

When his condition improved a barium enema was done and this revealed an infiltrating lesion of the transverse colon. The outline of the colon in this area was ragged with multiple filling defects which were thought to be due to a polypoid lesion. The conclusion was that this was a neoplasm with polypoid components. Upper GI X-rays and a cholecystogram were within normal limits. **Fig. 2.**

A few days later the patient developed intestinal obstruction and was subsequently operated upon and at surgery the right colon was found to be distended to about twice its normal size. The distention ended abruptly just to the right of the mid-colic artery. Several masses of various sizes were felt in the right colon. They were of a hard rubbery consistency. In the vicinity of the head of the pancreas there were several large lymph nodes which were biopsied and revealed a chronic non-specific inflammatory change with marked sclerosis of undetermined etiology. A right colectomy was performed with an ileotransverse colostomy. The postoperative course was uneventful.

Pathology

The segment of colon was 32 cm. long and had an attached appendix and a 2.5 cm. portion of ileum. The wall of the colon was crepitant and varied from 0.5 to 1.7 cm. thick. The intact pale mucosa of the colon was irregularly elevated by many single or multi-lobulated polypoid gas-filled blebs composed of single and multi-loculated thin-walled cysts which measured up to 1.5 cm. in diameter. The cysts were present from the submucosa to the subserosa. **Fig. 3.**

Microscopically, many of the cysts were partially lined by flattened cells, by cuboidal or rounded, large mononuclear cells, frequently by multinucleated giant cells and occasionally by collections of epitheloid cells. There was a thin acidophilic hyaline membrane overlying the lining cells in some cysts. Some of the smaller cysts were surrounded by varying degrees of fibrosis containing small numbers of small mononuclear cells, chiefly lymphocyte and plasma cells. The muscularis mucosa was apparently intact throughout. The lamina propria showed mild edema and chronic inflammation in many areas overlying the cysts and a few scattered crypts show microcyst formation. **Fig. 4.**

Although the cystic changes were present in the cecal portion of the ileocecal valve, no changes were observed in the ileum or appendix. The diagnosis is pneumatosis cystoides intestinalis. The usual intestinal flora was cultured from the lumen of the colon and from a cyst.

One and a half years later the patient was readmitted because of congestive heart failure and vague abdominal pain. A barium enema revealed pneumatosis cystoides intestinalis in the residual of the transverse colon. Except for the mild pain, he had no other GI symptoms. He eventually died in right heart failure.

Summary

Pneumatosis cystoides intestinalis is considered a symptomless, pathological curiosity. The etiology is uncertain. Occasionally, it will give rise to intussusception, pneumo-peritoneum from a ruptured cyst, volvulus and obstruction.

The case presented is that of pneumatosis cystoides intestinalis causing abrominal pain and intermittent partial bowel obstruction for which a right hemicolectomy was done. The presence of associated pulmonary fibrosis was noted by other authors and seems to be more than a coincidental finding. The difficulties in X-ray interpretation are stressed. The possibility of recurrence is mentioned.

References

1. Koss, L. G. (1952) Arch. Path., 53, 523.
2. Naeslund T. Zur Kenntnis der Pneumatosis Cystoides Intestinorum (Thesis) Uppsala: Isaac Markus.

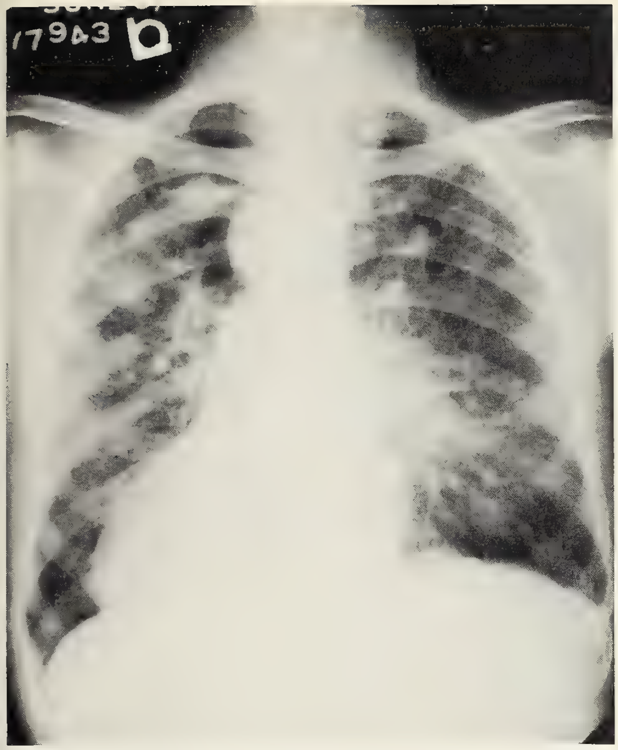


Fig. 1: Extensive interstitial fibrosis is seen throughout both lungs involving mainly the upper lung fields and right perihilar region. There is a tendency of confluence in the left intraclavicular region. There are emphysematous changes. The heart is moderately enlarged. The pulmonary conus is prominent.

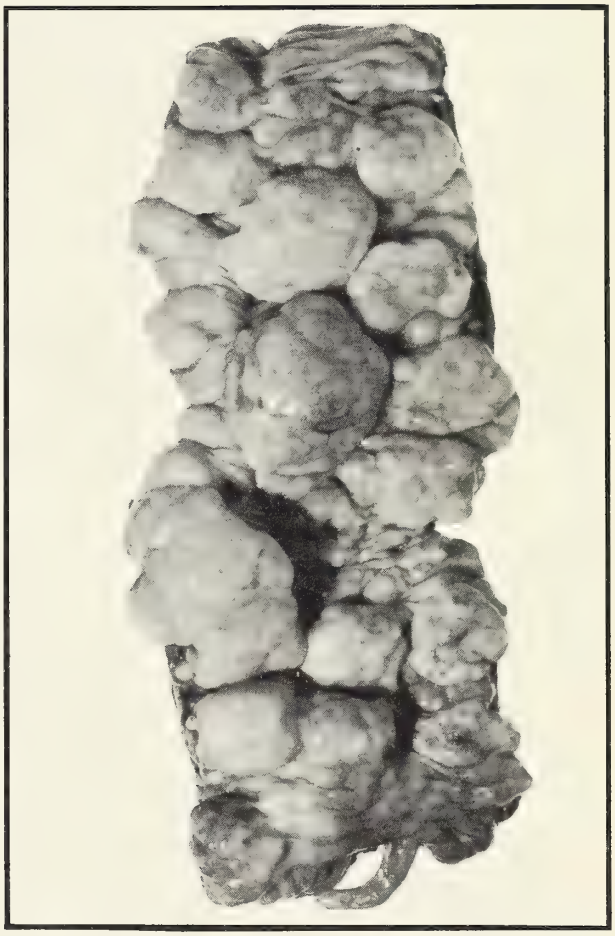


Fig. 3: Mucosa of colon elevated by multilobulated polypoid gas-filled cysts.

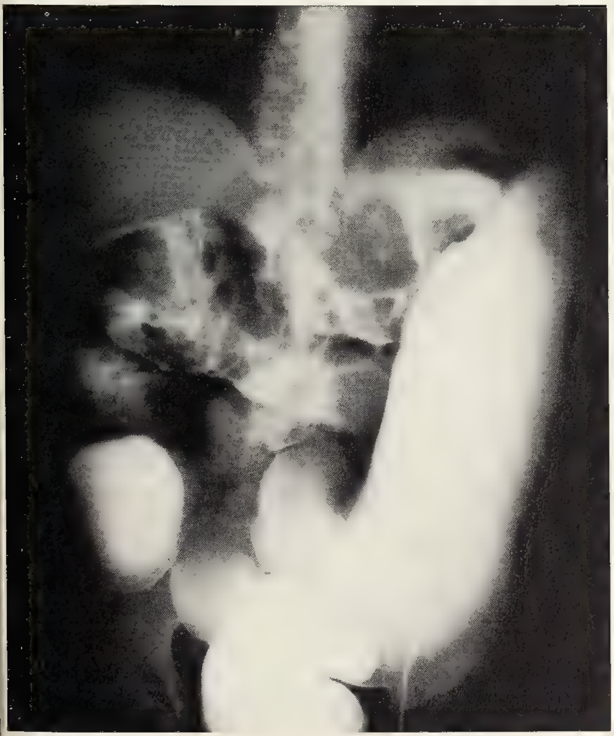


Fig. 2: There is an infiltrating lesion in the transverse colon. The outline of the colon in this area is ragged, and there are multiple filling defects.

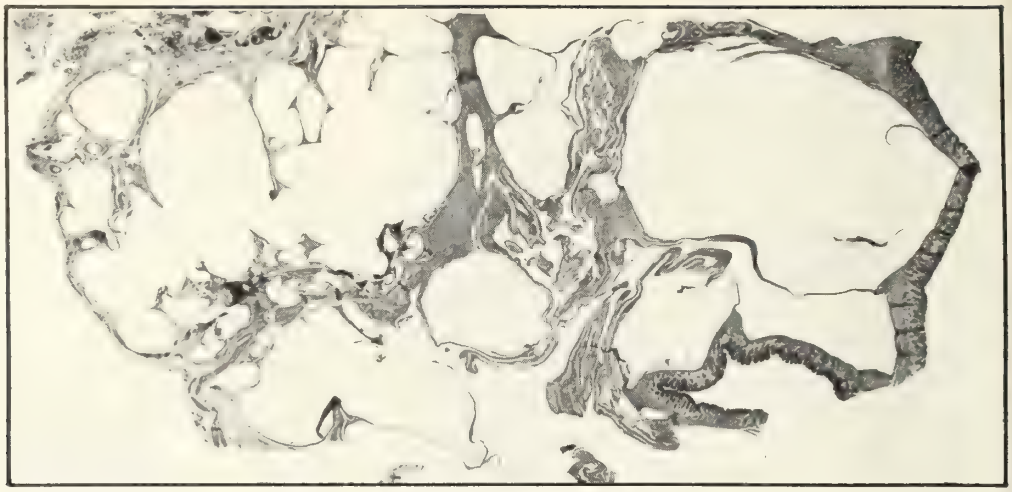


Fig. 4: Colon distended by thin-walled cysts which extend from submucosa to subserosa. Hemotoxylin and eosin x 6.

3. Druckman, A., Schwartz, A., Rabinovici, N. and Feurcht-Wanter, J. (1961) Amer. J. Roentgenol. 86, 911.
4. Maeklin, C. C.: Transport of Air Along Sheaths of Pulmonic Blood Vessels from Alveoli to Mediastinum: Clinical Implications. Arch. Intern. Med. (Chicago) 64:913-926, (Nov.) 1939.
5. Domb, H. P. and Shea, J. J.: Pneumatosis cystoides intestinalis. J. AMA 172:1238-1242, 1960.
6. Alford, J. E., Galetti, G., and Culver, G. J.: Pneumatosis cystoides intestinalis. Am. J. Surg. 92:648-656, 1956.
7. Smith, B. H., and Welter, L. H.: Pneumatosis Intestinalis. Am. J. Clin. Path. 48:455-465, 1967.
8. Calne, R. Y. (1959) Brit. J. Surg. 47, 212.
9. Shoesmith, J. H., and Crone, W. P. (1958) Brit. J. Surg. 46, 60.

MICHIGAN
DEPARTMENT
OF PUBLIC
HEALTH

Monthly Surveillance Report

Cases of Certain Diseases Reported To the Michigan Department of Public Health

For the Four-Week Period Ending June 26, 1970

	1970 This 4-Week Period	1969 Same 4-Week Period	1970 Total To Above Date	1969 Total Same Date	Total Cases for 1969
Rubella	366	712	2385	3340	4307
Measles	388	44	1278	185	401
Whooping Cough	10	7	51	61	192
Diphtheria	—	—	—	—	—
Mumps	927	497	4453	3600	5215
Scarlet Fever & Strep Sore Throat	834	487	7387	5785	9763
Tetanus	0	1	4	2	6
Poliomyelitis (paralytic)	—	—	—	—	—
Hepatitis	319	242	2221	1568	3360
Salmonellosis (other than S. typhi)	53	49	280	227	539
Typhoid Fever (S. typhi)	1	1	6	4	6
Shigellosis	11	16	95	147	300
Aseptic Meningitis	7	1	27	36	179
Encephalitis	8	8	41	48	120
Meningococcic Meningitis	11	11	43	82	114
H. Influenza Meningitis	6	3	33	27	56
Tuberculosis	118	148	1033	1149	2108
Syphilis	261	295	1903	2207	4021
Gonorrhea	1579	1345	9848	8567	19194

Information can be supplied by the local health department on the local incidence of disease.

Maurice Reizen, M.D., Director
Michigan Department of Public Health

Hospital Care in 1967 For Cerebrovascular Disease

By Charles M. Wylie, M.D., Dr., P.H.
Ann Arbor
Kenneth W. Teich, M.D.
McKeesport, Pa.

In recent years a number of writers have urged that society should do more for patients with cerebrovascular disease, and have implied that this large group of older patients has been medically and socially neglected in the past.[1, 2] The reports of the President's Commission on Heart Disease, Cancer, and Stroke strengthened this view, although the Commission's expert opinion had to be based on existing data which left many questions dangling in mid-air.[3] Following these reports, Regional Medical Programs have formed throughout the USA, including Michigan, to help improve the poorly coordinated arrangements for health care. Their initial efforts, however, have raised some scepticism that patient care will truly improve as a result of "better cooperative arrangements" which form the main goal of these programs.[4]

Good planning for Regional Medical Programs relies partly on good information being available to pin-point the problems which must be solved. The purpose of this paper is to provide more information about acute hospital care for cerebrovascular disease in Michigan; it will first analyze the performance of hospitals in caring for patients with cerebrovascular disease in 1967, following which we plan to discuss some preliminary judgments which arise from the findings.

Method of Study

During 1967 in Michigan, 96 short term general hospitals participated in the Professional Activity Study (PAS) program of the Commission on Professional and Hospital Activities in Ann Arbor. For each patient discharged from these hospitals, important clinical data were summarized on a case abstract form which the hospital mailed to Ann Arbor. The Commission then analyzed these data primarily to return to each hospital information that would help its medical staff evaluate and improve the care of patients. The data were analyzed further to produce the tables presented in this paper.

The participating hospitals formed just under half of all hospitals in the state. Being larger than average, however, they discharged more than half of all patients hospitalized in Michigan. Thus the 96 hospitals discharged 678,818 patients in all diagnostic groups in 1967; 8,264 patients, or 1.1 per cent of all discharges had a diagnosis of cerebrovascular disease[5] listed as the primary cause of admission. An additional group of 4,897 patients had a stroke diagnosis secondary to some other primary condition. The following analyses will focus, however, only on the first group, the 8,264 patients in whom cerebrovascular disease was held to be the primary cause of admission.

Length of Stay, by Age and Diagnosis

In **Table 1** the data are summarized which describe the age distribution of the patients; this is correlated with the average number of days spent in hospital. It, at once, becomes clear that more than half of all patients in this study were elderly, aged 70 years and older. The average stay in hospital lengthened with rising age, ranging from a minimum of 12 days for the youngest patients under 30 years to a maximum of 21 days for the large group aged 70 and older. It should be pointed out that dead as well as live discharges are included in this study, as we wish to describe events occurring in the total group. Most deaths took place soon after admission and became more numerous with rising age; the length of stay of live discharges, therefore, increased much more with age than is shown in **Table 1.** Thus, utilization review committees in these hospitals, focusing on patients discharged alive, must expect to find average stays that are longer than those shown in **Table 1.**

In **Table 2** patients are allocated to the diagnostic groupings which were commonly used for

---

Doctor Wylie is a professor of public health administration at the University of Michigan, and Doctor Teich was a medical audit consultant with the Commission on Professional and Hospital Activities in Ann Arbor. Doctor Teich is now Chief of Obstetrics and Gynecology, McKeesport Hospital, Pennsylvania.

Table 1

Age Distribution and Average Stay in Days of Patients with Cerebrovascular Disease discharged from 96 PAS Hospitals in Michigan in 1967.

	All Ages	Under 30	30-39	40-49	50-59	60-69	70 or older
			Age in Years				
Number of Patients	8,264	144	117	392	1,033	2,029	4,549
Average Stay (Days)	19.4	12.0	13.6	16.2	15.9	18.2	21.3

Table 2

Some Characteristics of Patients within different Diagnostic Categories of Cerebrovascular Disease, discharged from 96 PAS Hospitals in Michigan in 1967.

Diagnosis	Number of Patients	Average Days of Stay	% with Operations	% Dead on Discharge
All Cerebrovascular Disease	8,264	19.4	16	26.8
Subarachnoid Hemorrhage	358	17.0	50	40.8
Cerebral Hemorrhage	3,224	21.5	10	40.2
Embolism & Thrombosis	2,322	21.5	15	27.6
Transient Ischemia ("Cerebral Spasm")	212	9.1	8	1.4
Other and Ill Defined Lesions	2,148	15.3	17	5.9

Table 3

Average Stay and Mortality in 8,264 Patients with Cerebrovascular Disease discharged from 96 PAS Hospitals in Michigan in 1967, by Hospital Size.*

	Total	Smallest	Small	Medium	Large	Largest
		Hospital Size				
Number discharged	8,264	662	1,353	2,159	1,672	2,418
Average stay (days)	19.4	25.2	23.1	19.3	17.6	16.9
Dead on discharge (%)	26.8	30.5	28.2	26.5	27.8	24.5

*Please see Ref. (6) for definitions of hospital size.

statistical analysis in 1967. The second column of figures in this table shows that the two largest groups, patients with cerebral hemorrhage and with embolism and thrombosis, had the longest stay, averaging just over 3 weeks. Patients with subarachnoid hemorrhage, while usually as seriously ill as cerebral hemorrhage patients and showing a similar mortality, had a shorter average stay because of their younger age distribution. Patients with transient ischemia, usually allocated to the old statistical category of "spasm" in 1967, formed the group with the shortest average stay.

Hospital Size, By Average Stay and Mortality

Each hospital was allocated to one of five size groups, according to the total number of patients in all diagnostic groups who were discharged by the hospital in 1967.[6] Thus, the group of smallest hospitals was formed by the 23 which discharged less than 2,500 total patients. **Table 3** shows that both the average stay and proportion dying fell with the rising size of the hospital. Since most deaths in this study occurred within a few days

Table 4

Proportion Dead among 8,264 Cerebrovascular Disease Discharges, by Average Number of Different Tests Performed in the Hospital from which Discharged.

	Average Number of Tests				
	8 or less	9-10	11-12	13-14	15 or more
Dead on Discharge	32.8%	29.5%	25.3%	26.6%	23.2%

Table 5

Proportion Dead among 8,264 Cerebrovascular Disease Discharges, by Average Number of Different Tests Performed and by Teaching Status* of Hospital.

	Teaching Hospitals*		Nonteaching Hospitals	
Average Number of Tests	Number Discharged	Dead	Number Discharged	Dead
11 or less	533	27.6%	2,899	29.7%
12 or more	3,576	24.5%	1,256	26.2%

*Teaching hospitals were those approved for training interns and residents.

of admission — one-third taking place, for example, within two days — the longer stay in smaller hospitals was not the main cause of their higher mortality.

Many factors, as well as quality of care, could cause the differences in deaths. One factor is age, and our analyses do show that younger patients tend to enter larger hospitals.[4] Perhaps most important is the possibility, however, that smaller hospitals may admit patients who are more seriously ill, and who thus have a greater chance of dying. In a recent paper, however, we have presented evidence that this does not occur;[4] indeed, the available information suggests that smaller hospitals receive the less seriously ill patients. Since the age differences are not large enough to account entirely for the variation in mortality, the hypothesis must be examined that physicians in larger hospitals may have more resources which help them do more for their patients with cerebrovascular disease than physicians in smaller hospitals.

Testing Effort and Mortality

A total of 64 different procedures could be marked on the case abstract as having been done once or more during the stay. The average number of different laboratory tests was calculated for the patients with cerebrovascular disease from each hospital. This figure ranged from a low of 6 different tests performed on 45 discharges from one hospital to the maximum average of 22 tests completed in another hospital with 96 discharges. Because the testing effort was more extensive in hospitals which were approved for the training of interns and residents, termed "teaching" hospitals in this study, some tables which follow divide the institutions into "teaching" and "nonteaching" hospitals.

Table 4 correlates the average number of tests performed with the proportion dead on discharge. Among all patients discharged from hospitals performing an average of 8 tests or less, 32.8 per cent had died in hospital. At the other end of the scale, hospitals performing an average of 15 or more tests had 23.2 per cent of patients dead on discharge. This table shows that the proportion dead tended to fall with the rising average number of tests.

Table 5 separates the findings for teaching and non-teaching hospitals. In the teaching group, patients from hospitals performing 11 or less tests included significantly more deaths than did patients involved in a greater testing effort. In the nonteaching hospitals, mortality figures were higher than for teaching hospitals but showed a similar fall with an increase in tests. These findings are compatible with a belief that the testing effort also needs adequate follow-up of abnormal tests, and that this is better accomplished when interns and residents are present. This explanation is a hypothesis only, however, for we do not know that this follow-up effort truly did occur.

Hospital Size, Teaching Status, and Testing Effort

Table 6 shows the average number of tests performed on patients with cerebrovascular disease in hospital groups of different size and teaching status. This figure tended to rise with increasing size of hospital; within the same size group, pa-

Table 6

Average Number of Tests Performed on 8,264 Patients with Cerebrovascular Disease in Michigan in 1967, by Hospital Size and Teaching Status.

Teaching Status	Total	Hospital Size Smallest	Small	Medium	Large	Largest
All Hospitals	11.9	9.3	9.7	11.6	12.6	13.7
Teaching	13.1	—	12.5	11.4	12.6	13.8
Nonteaching	10.8	9.3	9.6	11.6	12.5	11.6

Table 7

Frequency with which Good Control Measures were Taken in Treating 8,264 Patients with Cerebrovascular Disease in Michigan in 1967, by Hospital Size.

	Total	Smallest	Small	Hospital Size Medium	Large	Largest
Number discharged	8,264	662	1,353	2,159	1,672	2,418
(a) Given parenteral fluids	2,966	196	367	774	683	946
Electrolytes determined per cent of (a)	55	21	32	49	61	71
(b) Given antibiotics	2,692	254	463	753	519	703
Antibiogram performed per cent of (b)	24	9	10	24	31	32

tients in teaching hospitals usually received more tests than those in nonteaching hospitals.

When we correlate these findings with the reduced mortality which occurs in larger hospitals, the belief seems possible that more extensive tests should produce more valid diagnoses, to be followed by more specific and effective methods of treatment with lower death rates. In what way then does the treatment differ in the various hospital groups?

Hospital Size And Treatment Effort

Therapeutic measures in cerebrovascular disease may be divided into non-specific medical and nursing care, which help sustain life and function in all seriously ill patients, and more specific measures that are indicated for limited groups of patients.

Table 7 assesses the quality of two measures of non-specific care. Parenteral fluids are indicated for all patients who cannot safely take fluids by mouth. When given parenterally, however, their administration should be monitored by the periodic determination of electrolytes in the blood. The table shows that this advisable step was performed rarely in the smallest hospitals in Michigan, and with increasing frequency as hospital size rose. In small, nonteaching hospitals, it is possible that the observations of nurses had partly to replace the more adequate information given by this test.

Antibiotics are given to the sizeable proportion of stroke patients who develop infections during their hospital stay, and possibly to prevent infection as well. When time is available to select the most suitable antibiotic, an antibiogram should ideally be performed to determine the degree of susceptibility of the infecting organism to available antibiotics. **Table 7** shows that this useful step was largely ignored in the smallest hospitals, and was performed more often as hospital size increased. The items in the table tend to confirm, therefore, that the quality of medical treatment seemed to improve with increasing size of hospital. We need more comprehensive information, however, to place this belief on a more certain basis.

Further Discussion Of the Findings

The 96 hospitals which took part in the PAS program in 1967 are not likely to have provided worse care, and probably provide better care on average than the group which did not participate in this program. We believe, therefore, that the picture obtained from the participating hospitals in this study does not exaggerate the achievements and problems of hospital care in Michigan.

The evidence seems good, presented in a previous paper,[4] that more seriously ill patients tend to enter larger hospitals. These larger hospitals should thus experience higher death rates in patients with cerebrovascular disease. Since death figures in this study fell with increasing hospital size, it seems likely that improvements in diagnosis and treatment help to prevent a proportion of deaths in larger hospitals. The tables in this study do indeed confirm that the diagnostic effort is more intense and the treatment effort under better control in larger than in smaller hospitals.

In practice, however, many smaller hospitals are not satisfactorily staffed or equipped to perform safely some complex procedures such as angiography. For patients in whom angiography is most strongly indicated, particularly those in whom subarachnoid hemorrhage or transient ischemia is suspected, it is to be hoped that regional medical programs will facilitate their transfer to larger institutions where the procedure can be carried out skillfully and safely. In this study, few patients with transient ischemia underwent angiography, which is needed to identify the considerable group with operable lesions in the neck vessels.

While recognizing the practical problems of providing ideal care in small hospitals, it does seem feasible to introduce some ingredients of improved care into these institutions. More numerous tests are needed to make more specific diagnoses. The educational program, which may be organized to draw the physicians' attention to the usefulness of more tests, will also need to ensure that abnormal results are adequately followed up. Perhaps most needed, however, is that the educational program truly convince the physicians that high quality care for cerebrovascular disease will be worthwhile. A more intensive diagnostic and treatment effort must produce better end results to be worth the rise in cost of care. We believe that the data presented in this paper gives tentative evidence that this is so.

Acknowledgement

Vergil N. Slee, M.D., M.P.H., contributed greatly to the ideas tested and the technics used in this study.

References

1. Wylie, C. M.: Hospital Care for Patients with Strokes in the Acute Stage, J. Amer. Med. Assoc. 199:791, 1969.
2. Borhani, N. O., and Meyer, J. S., Editors: Medical Basis for Comprehensive Stroke Programs, Bethesda, Md., Division of Regional Medical Programs, 1968.
3. A National Program to Conquer Heart Disease, Cancer and Stroke. President's Commission on Heart Disease, Cancer and Stroke, U.S. Government Printing Office. Vol. 1, 1964; Vol. 2, 1965.
4. Wylie, C. M.; Teich, K. W., and Slee, V. N.: Evaluating the Stroke Effort in Regional Medical Programs, Amer. J. Pub. Health 59:974, 1969.
5. ICDA Code Range 330.0 - 334.9. *International Classification of Diseases, Adjusted for Indexing Hospital Records by Diseases and Operations.* U.S. Public Health Service, Publication No. 719, Revised Edition, 1962.
6. Hospital size was assessed according to the total number of patients in all diagnostic groups who were discharged by the hospital in 1967. The five size groups were: Smallest — less than 2,500 total patients discharged per year; Small — 2,500-4,999 total patients discharged per year; Medium — 5,000-9,999 total patients discharged per year; Large — 10,000-14,999 total patients discharged per year; Largest — 15,000 or more total patients discharged per year.

In Dogs

Effect of Histamine and Aspirin On Healing of Acute Acetic Acid Ulcers

By Choichi Sugawa, M.D.
Charles E. Lucas, M.D.
Alexander J. Walt, M.D., F.A.C.S.
All of Detroit

The following is an abstract of a paper presented at the April meeting of the Detroit Surgical Association.

Experimental ulcers, made by an intramural injection of 0.5 ml. 40% acetic acid in the antrum and body of 24 dogs, grew to maximum diameter averaging 12 mm. and penetrating to the serosa in one week. The dogs were divided into three groups to observe, by weekly gastroscopy with a fiberoptic gastroscope with camera, the effects of histamine (I.M. histamine in beeswax, 2 mg/kg/day) in eight dogs (Gp. H), aspirin (ASA in drinking water, 120 mg/kg/day) in seven dogs (Gp. ASA), and normal healing in nine dogs (Gp. C). Serum salycilate levels in Gp. ASA averaged 11.2 mg.%. Histological changes were observed on H&E, PAS, and mucicarmine stains obtained at autopsy at three, six and seven weeks.

The ulcer index (UI, product of length x width in mm^2) averaged 148 at one week for both antral and body ulcers. All control ulcers were much smaller at three weeks and completely healed at six weeks. All histamine ulcers showed delayed healing at three and six weeks. In Gp. ASA, antral ulcers healed normally but body ulcers showed delayed healing at three and six weeks. Gastric mucin staining of non-ulcerated antral and fundic mucosa correlated directly with the degree of ulcer healing. Since PAS selectively stains neutral mucoproteins covering the gastric mucosa, this decrease in staining can be interpreted as a decrease in mucin protection of the gastric mucosa against acid digestion. Scattered mucosal erosions and petechiae, not seen in controls (C), developed throughout the stomach in Gp. H dogs and in the body of Gp. ASA dogs. Histologically these experimental ulcers healed like human peptic ulcer with the exception that there was no superficial necrotic layer consisting of fibrin, polymorphonucleocytes, and red blood cells.

This study describes a new method for producing experimental chronic gastric ulcers which heal in the same manner as human peptic ulcers. Follow-up was facilitated by the fact that gastrotomy was avoided at the time of ulcer production and the fiberoptic gastroscope with camera was utilized weekly to visualize healing prior to later autopsy. In addition, the retarding effect of systemic histamine and aspirin on the healing process of these ulcers has been demonstrated along with a corresponding decrease in superficial gastric mucin staining.

The authors are with the Robert S. Marx Surgical Laboratories and the Department of Surgery, Wayne State University School of Medicine.

Michigan Authors

Joseph D. Mann, M.D., and Charles E. Jackson, M.D., Grand Rapids, "Contributions of the Xg^a Blood Group System to Medicine," page 432, *The Journal of the Indiana State Medical Association,* May, 1970.

F. J. deCastro, M.D., Ann Arbor, "Delayed Aqueous Hyposensitization Reaction," page 1069, *Journal of the American Medical Association,* May 11, 1970.

F. J. Salter, Pharm.D., and R. E. Pearson, M.S., Ann Arbor, "Potassium Supplementation," page 1526, *Journal of the American Medical Association,* June 1, 1970.

Dennis R. Burke, M.D., Ypsilanti, "Ergogenic Aids and Athletics," page 12, *The Journal of the National Athletic Trainers Association,* summer, 1970.

Allen J. Enelow, M.D., East Lansing, Leta McKinney Adler, Ph.D., and Murray Wexler, Ph.D., Los Angeles, "Programmed Instruction in Interviewing," page 1843, *Journal of the American Medical Association,* June 15, 1970.

K. R. Magee, M.D., Ann Arbor, "Disorders of Voluntary Muscle," a book review, page 1964, *Journal of the American Medical Association,* June 15, 1970.

J. J. Voorhees, M.D., Ann Arbor, "Reaction to Methotrexate in Psoriasis," Questions and Answers, *Journal of the American Medical Association,* May 4, 1970.

PROTEIN CONTENT / 7 oz. Serving*

Bean with Bacon	6.8	Green Pea with Ham (Frozen)	7.6
Beef	8.0	Hot Dog Bean	8.4
Chicken Broth	5.5	Pepper Pot	6.1
Chicken 'N Dumplings	5.8	Split Pea with Ham	10.2
Chili Beef	6.2	Vegetable Beef	5.0
Green Pea	6.9	Vegetable with Beef (Frozen)	5.4

When protein is the focal point in your patients' special diets, Campbell's Soups can be a convenient supplementary source of that essential nutrient.

*From "Nutritive Composition of Campbell's Products" which gives values of important nutritive constituents of all Campbell's Products. For your copy, write to Campbell Soup Company, Dept. 365, Camden, New Jersey 08101.

here's a soup
for almost every patient and diet
..for every meal
and, it's made by Campbell

You Can't Blame a Girl...

(when her
husband's
at fault)

Flagyl® brand of metronidazole

Cures Trichomoniasis in Both Women and Men

About half of all husbands of infected women harbor *Trichomonas vaginalis.**

Few of these men have symptoms. Even so, all are capable of perpetuating the infection and rendering treatment of a woman alone futile.

Only a systemically active medication like Flagyl is capable of reaching the hidden reservoirs of infection in the genitourinary tracts of both men and women.

Only Flagyl has been able to achieve rates of cure consistently above 90 per cent and often up to 100 per cent in trichomonal infections in both men and women.

Indications: For the treatment of trichomoniasis in both male and female patients and the sexual partners of patients with a recurrence of the infection provided trichomonads have been demonstrated by wet smear or culture.

Contraindications: Evidence of or a history of blood dyscrasia, active organic disease of the central nervous system and the first trimester of pregnancy.

Warnings: Use with discretion during the second and third trimesters of pregnancy and restrict to patients not cured by topical measures. Flagyl (metronidazole) is secreted in the breast milk of nursing mothers. It is not known whether this can be injurious to the newborn.

Precautions: Mild leukopenia has been reported during Flagyl use; total and differential leukocyte counts are recommended before and after treatment with the drug, especially if a second course is necessary. Avoid alcoholic beverages during Flagyl therapy because abdominal cramps, vomiting and flushing may occur. Discontinue Flagyl promptly if abnormal neurologic signs occur. There is no accepted proof that Flagyl is effective against other organisms and it should not be used in the treatment of other conditions. Exacerbation of moniliasis may occur.

Adverse Reactions: Nausea, headache, anorexia, vomiting, diarrhea, epigastric distress, abdominal cramping, constipation, a metallic, sharp and unpleasant taste, furry or sore tongue, glossitis and stomatitis possibly associated with a sudden overgrowth of *Monilia,* exacerbation of vaginal moniliasis, an occasional reversible moderate leukopenia, dizziness, vertigo, drowsiness, incoordination and ataxia, numbness or paresthesia of an extremity, fleeting joint pains, confusion, irritability, depression, insomnia, mild erythematous eruptions, "weakness," urticaria, flushing, dryness of the mouth, vagina or vulva, vaginal burning, pruritus, dysuria, cystitis, a sense of pelvic pressure, dyspareunia, fever, polyuria, incontinence, decrease of libido, nasal congestion, proctitis, pyuria and darkened urine have occurred in patients receiving the drug. Patients receiving Flagyl may experience abdominal distress, nausea, vomiting or headache if alcoholic beverages are consumed. The taste of alcoholic beverages may also be modified.

Dosage and Administration: *In the Female.* One 250-mg. tablet orally three times daily for ten days. Courses may be repeated if required in especially stubborn cases; in such patients an interval of four to six weeks between courses and total and differential leukocyte counts before, during and after treatment are recommended. Vaginal inserts of 500 mg. are available for use, particularly in stubborn cases. *When the vaginal inserts are used* one 500-mg. insert is placed high in the vaginal vault each day for ten days and the oral dosage is reduced to two 250-mg. tablets daily during the ten-day course of treatment. Do not use the vaginal inserts as the sole form of therapy. *In the Male.* Prescribe Flagyl only when trichomonads are demonstrated in the urogenital tract, one 250-mg. tablet two times daily for ten days. Flagyl should be taken by both partners over the same ten-day period when it is prescribed for the male in conjunction with the treatment of his female partner.

Dosage Forms: Oral tablets . . . 250 mg.
Vaginal inserts . . 500 mg.

*References available on request.

SEARLE
P. O. Box 5110
Chicago, Illinois 60680

942

Research in the Service of Medicine

JUDGE ANTIBIOTIC OINTMENTS HERE

Results on skin are final proof of any topical antibiotic's effectiveness

No in vitro test can duplicate a clinical situation on living skin. 'Neosporin' (polymyxin B—bacitracin—neomycin) Ointment has consistently proven its effectiveness in thousands of cases of bacterial skin infection. The spectra of the three antibiotics overlap in such a way as to provide bactericidal action against most pathogenic bacteria likely to be found topically. Diffusion of the antibiotics from the special petrolatum base is rapid since they are insoluble in the petrolatum, but readily soluble in tissue fluids. The Ointment is bland and nonirritating.

Caution: As with other antibiotic preparations, prolonged use may result in overgrowth of nonsusceptible organisms and/or fungi. Appropriate measures should be taken if this occurs. Articles in the current medical literature indicate an increase in the prevalence of persons allergic to neomycin. The possibility of such a reaction should be borne in mind.

Contraindications: This product is contraindicated in those individuals who have shown hypersensitivity to any of its components.

Supplied: Tubes of 1 oz., ½ oz. with applicator tip, and ⅛ oz. with ophthalmic tip.

Complete literature available on request from Professional Services Dept. PML.

'NEOSPORIN'®
brand

POLYMYXIN B-BACITRACIN-NEOMYCIN
OINTMENT

BURROUGHS WELLCOME & CO. (U.S.A.) INC., Tuckahoe, N.Y.

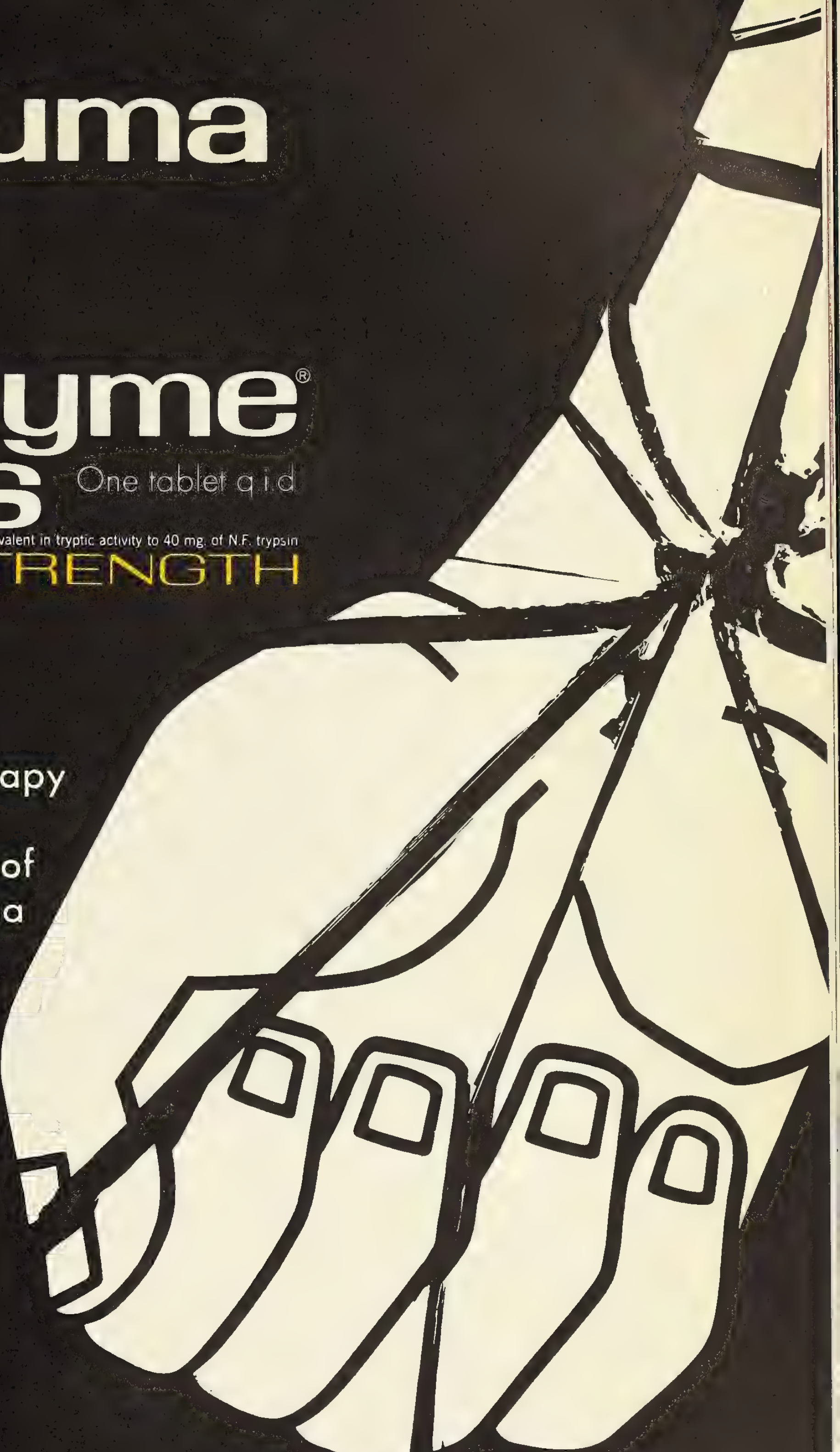
in trauma

new Orenzyme® Bitabs

One tablet q.i.d.

Trypsin: 100,000 N.F. Units, Chymotrypsin: 8,000 N.F. Units.; equivalent in tryptic activity to 40 mg. of N.F. trypsin

DOUBLE STRENGTH



Proteolytic enzyme therapy specifically indicated for the rapid resolution of inflammation and edema as adjunctive therapy in accidental and surgical trauma.

1 tablet q.i.d. provides recommended therapeutic dose at lower cost.

A FULL DAY'S DOSAGE

Description: ORENZYME BITABS offers the therapeutic effects of trypsin in an oral form as adjunctive therapy for the rapid resolution of inflammation and edema. ORENZYME BITABS is convenient to use, promotes patient cooperation and is ideally suited for maintenance therapy following parenteral trypsin.

Indications: When used as adjunctive therapy for the rapid resolution of inflammation and edema, good results have been obtained in:

☐ Accidental Trauma
☐ Postoperative Tissue Reactions.

Other conventional measures of treatment should be used as indicated. In infection, appropriate anti-infective therapy should be given.

Contraindications: ORENZYME BITABS should not be given to patients with a known sensitivity to trypsin or chymotrypsin.

Precautions: It should be used with caution in patients with abnormality of the blood clotting mechanism such as hemophilia, or with severe hepatic or renal disease. Safe use in pregnancy has not been established.

Adverse Reactions: Adverse reactions with ORENZYME have been reported infrequently. Reports include allergic manifestations (rash, urticaria, itching), gastrointestinal upset and increased speed of dissolution of animal-origin surgical sutures. There have been isolated reports of anaphylactic shock, albuminuria and hematuria. Increased tendency to bleed has also been reported but, in controlled studies, it has been seen with equal incidence in placebo-treated groups. (See Precautions.) It is recommended that if side effects occur medication be discontinued.

Dosage: One tablet q.i.d.

THE NATIONAL DRUG COMPANY
DIVISION OF RICHARDSON-MERRELL INC.
PHILADELPHIA, PENNSYLVANIA 19144

TRADEMARK: BITABS U.S. PATENT NO. 3,004,893 4/69 0-821A

Treating vaginitis is as easy as AVC

Trichomonads...Monilia...Bacteria

You can depend on AVC—the comprehensive therapy that acts against all three major vaginal pathogens.

Monilia emerging as a major therapeutic problem—

recent studies report increased incidence, attributed in part to the use of oral contraceptives,[1-4] broad-spectrum antibiotics[5-9] and prolonged use of corticosteroids.[7]

recent evidence establishes high rate of microbiological and clinical cure with AVC.[9-11]

Comprehensive—Effective

The published record and more than two decades of clinical experience clearly establish the therapeutic value of AVC in vaginitis/cervicitis and vaginal surgery.

Easy as AVC

Contraindications: Known sensitivity to sulfonamides.

Precautions/Adverse Reactions: The usual precautions for topical and systemic sulfonamides should be observed because of the possibility of absorption. Burning, increased local discomfort, skin rash, urticaria or other manifestations of sulfonamide toxicity are reasons to discontinue treatment.

Dosage: One applicatorful or one suppository intravaginally once or twice daily.

Supplied: Cream—Four-ounce tube with or without applicator. Suppositories—Box of 12 with applicator.

References: 1. Gardner, H. L.: J. Miss. M.A. 8:529, 1967. 2. Porter, P. S., and Lyle, J. S.: Arch. Dermat. 93:402, 1966. 3. Walsh, H.; Hildebrandt, R. J., and Prystowsky, H.: Am. J. Obst. & Gynec. 93:904, 1965. 4. Vaginitis and the Pill: J.A.M.A. 196:731, 1966. 5. Guerriero, W. F.: South. M.J. 56:390, 1963. 6. Seelig, M. S.: Am. J. Med. 40:887, 1966. 7. To-day's Drugs, New York, Grune & Stratton, Inc., 1965, p. 316. 8. Gray, L. A., and Barnes, M. L.: Am. J. Obst. & Gynec. 92:125, 1965. 9. Salerno, L. J.; Ortiz, G., and Turkel, V.: Vaginitis: A Diagnostic and Therapeutic Approach, Scientific Exhibit, presented at the 115th Annual A.M.A. Convention, Chicago, Illinois, June 1966. 10. Walsh, J. C.; Sheffery, J. B., and Wilson, T. A.: Med. Ann. D.C. 37:358, 1968. 11. Nugent, F. B., and Myers, J. E.: Pennsylvania Med. 69:44, 1966.

THE NATIONAL DRUG COMPANY
DIVISION OF RICHARDSON MERRELL INC
PHILADELPHIA, PENNSYLVANIA 19144

AVC CREAM (aminacrine hydrochloride 0.2%, sulfanilamide 15.0%, allantoin 2.0%)

SUPPOSITORIES (aminacrine hydrochloride 0.014 Gm., sulfanilamide 1.05 Gm., allantoin 0.014 Gm.)

TRADEMARK: A V C   AV-919A 7/69

Extract of MSMS Council Meeting of May 27, 1970

MSMS To Begin Informational Campaigns

MAP Board – The Council appointed Bradley M. Harris, M.D., Ypsilanti, to the MAP Board to replace Luther R. Leader, M.D., who is retiring.

July 4 Bicentennial – The Council decided to notify the Pennsylvania Medical Society that MSMS would participate in some way in the bicentennial celebration of the signing of the Declaration of Independence. The celebration will be held in Philadelphia in 1976, and the Pennsylvania Society has requested MSMS to consider an exhibit at the bicentennial commemorating the advances of medicine in Michigan.

MDPH Committee – The Council learned that its recommendation of Arthur L. Tuuri, M.D., Flint, to serve on the Michigan Department of Public Health Committee to Establish Guidelines for Pediatric Services in Hospitals was accepted by the MDPH.

MHS Committee – The Council recommended that Robert M. Leitch, M.D., Union City, be reappointed to the Michigan Hospital Service Medical Advisory Committee, and that Raymond L. Hockstad, M.D., Escanaba, be appointed to the committee to replace Eugene R. Elzinga, M.D., Marquette, who has served two terms, assuring that problems from northern Michigan would continue to be represented.

MSU DO School – Doctor Taylor announced the appointment of K. H. Johnson, M.D., Justin L. Sleight, M.D., D. Bonta Hiscoe, M.D., and Robert M. Stow, M.D., all of Lansing, to the Ad Hoc Committee to meet with Dean Andrew D. Hunt, Jr., re the DO School at MSU.

MDMH Director – The Council authorized a letter to Gov. William G. Milliken respectfully recommending that E. Gordon Yudashkin, M.D., who is acting director of the Michigan Department of Mental Health, be appointed director. The governor has requested that MSMS provide names of specific persons whom MSMS feels would fill the position well.

AMA Dues – The Council instructed the Michigan Delegation to the AMA Annual Meeting in Chicago in June to oppose the recommendation that the AMA annual dues be raised $80.

Health Careersmobile – The Council approved a Finance Committee recommendation that an allocation of $2,500 be authorized to support the Health Careersmobile during the 1970 fiscal year.

Membership Folder – The Council decided to postpone allocation of funds for the publication of the proposed MSMS membership folder until the 1971 budget is prepared.

MMS Board – The Council authorized its chairman, Ross V. Taylor, M.D., to respond to a request by Michigan Medical Service Board Chairman Doctor Hamburg that MSMS form an official statement concerning utilization review and control, cost controls, service contrasted to indemnity payments and restraints on fee escalations.

Public Relations – The Council voted to discontinue the MSMS Committee on Scientific Radio and Television and give the Committee on Public Relations the responsibility for restructuring the MSMS-WUOM radio tape series. The Council authorized the Committee on PR to be responsible for promotional and educational activities for three-month campaigns on selected subjects. The Council authorized the Committee on PR to promote the sale and distribution of the AMA manual, *Today's Health Guide,* to physicians, component medical societies and others. The Council voted to request the Michigan Health Council to purchase sufficient copies of "Horizons Unlimited" for 1970 distribution.

Socio-Economics Committee – The Council decided to discontinue the MSMS Ad Hoc Committee to Study Health Problems of the Disadvantaged in the Cities and assigned the committee's goals and functions to the Committee on Medical Socio-Economics.

Health Boards – The Council authorized preparation of a bill to be introduced in the 1971 Michigan Legislature to provide a requirement that at least one physician (MD or DO) be a member of all county or district health boards.

Smoking and Health – The Council requested the Cardiac Disease Committee to prepare a policy statement on smoking and health and to suggest specific ways to implement its requests for a publicity campaign. The committee had earlier recommended that The Council adopt a policy statement requesting the MSMS membership to refrain from smoking in the presence of patients and recommending that every individual doctor do all he can to bring about the cessation of smoking.

CONSTIPATION
EVACUATE GENTLY

With EVAC-U-GEN — your patients with functional constipation can evacuate gently. Because EVAC-U-GEN has a mild laxative action and tends to cause the stool to be soft — it is highly desirable for those sensitive to harsh laxatives — particularly children, pregnant women, and geriatric patients. Recommend EVAC-U-GEN for the management of functional constipation. It is highly effective. Non-griping. Chewable. Very palatable. Economical.

EVAC-U-GEN®

A highly-flavored and palatable tablet of yellow phenolphthalein, bismuth subcarbonate, bismuth subgallate in special base. Chewable. Bottles of 35 and 100. Adult Dose: Chew 1 or 2 tablets night or morning. Children (up to age 10): 1/2 tablet. A citrus drink taken with tablet will stimulate action.
PRECAUTION: Do not use when symptoms of appendicitis are present and discontinue use if skin rash appears. Dependence on laxatives can result from continued use.

W-C PRECISION PHARMACEUTICALS

SEND FOR SAMPLES.
WALKER, CORP & CO., INC.
Syracuse, New York 13201

msms news

Michigan Mediscene

Sept. 20 — MSMS Council, Sheraton-Cadillac Hotel, Detroit, 9:30 a.m.

Sept. 20-24 — MSMS Annual Session, Sheraton-Cadillac Hotel, Detroit

Sept. 22-24 — 44th Annual Convention of Woman's Auxiliary to MSMS, Pontchartrain Hotel, Detroit

Sept. 23 — MSMS Council, Sheraton-Cadillac Hotel, Detroit, 8 a.m.

Sept. 24-25 — Michigan Society of Internal Medicine, Otsego Ski Club, Gaylord, Annual Dinner Meeting, Sept 24, Annual Luncheon, noon, Sept. 25

Sept. 24-27 — Annual Michigan Regional Meeting of the American College of Physicians in association with the Michigan Society of Internal Medicine, Otsego Ski Club, Gaylord

Sept. 26 — Medical Technology Seminar on Leukemias, Oakland Center, Oakland University

Sept. 26-27 — Leadership Training Seminar, Michigan State Medical Assistants Society, Campus Inn, Ann Arbor

Oct. 5-9 — 53rd Annual Meeting, American Dietetic Association, Detroit

Oct. 5-19 — MSMS Orient Adventure

Oct. 16-17 — Michigan State Association of Industrial Nurses Fall Conference, Holiday Inn, St. Joseph

Oct. 18-24 — 1970 Michigan Community Health Week

Oct. 21-22 — Annual fall meeting of the Michigan TB and Respiratory Disease Association, the Michigan Thoracic Society and the Michigan Conference of TB Association Workers, Northland Inn, Southfield

Nov. 4 — Special meeting of The Council, MSMS Headquarters, East Lansing, noon

Nov. 9-13 — International Drug Abuse Symposium, Towsley Center, University of Michigan

Nov. 11 — Michigan Cancer Coordinating Committee, MSMS Headquarters, East Lansing, noon

Nov. 29-Dec. 2 — Many Michigan physicians will participate in the annual AMA Clinical Convention in Boston

Dec. 9 — MSMS Council, MSMS Headquarters, East Lansing, 9:30 a.m.

Dec. 9 — 10th Annual Wayne State University Thyroid Workshop, Wayne County Medical Society Auditorium

Jan. 30-31 — Annual Winter Educational Seminar, State of Michigan Chapter, American Association of Medical Assistants, The Ramada Inn, Saginaw

April 30-May 2 — Annual Meeting, State of Michigan Chapter, American Association of Medical Assistants, Weber's Motor Inn, Ann Arbor

AMA Selects MSMS 1970 Annual Session For Special Meeting

The AMA Committee on Exercise and Physical Fitness, which each year sponsors one symposium, somewhere in the U.S., has selected the Michigan State Medical Society Annual Session for a major presentation on Wednesday, Sept. 23, at the Sheraton-Cadillac Hotel, Detroit.

The program, to be presented by authorities obtained by the AMA from across the nation, will be offered from 2 to 5 p.m. in the Washington Room of the Sheraton-Cadillac.

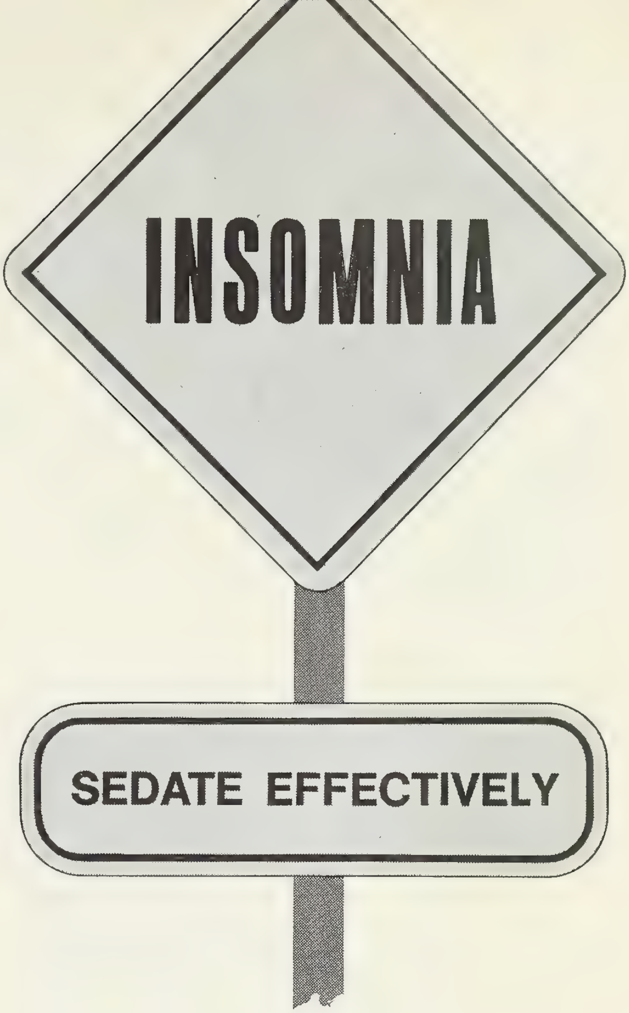
"The Symposium will be open to physicians and such key people from allied fields as rehabilitation workers, athletic trainers, physiology-of-exercise personnel, and others," points out Fred V. Hein, Ph.D., secretary of the AMA Committee on Exercise and Physical Fitness.

The AMA presented its 1969 symposium in Los Angeles with noted authorities discussing such subjects as "Exercise and the Cardiovascular System," "Prescribing Exercise Programs for the Well Patient," "Conditioning Exercises in a Physical Fitness Program," "Exercise Programs following Cardiovascular Episodes," and others.

Further details will appear in future issues of *Michigan Medicine*.

'Michigan Medicine' Article Included in Index Of National Health Library

The National Health Agencies Library staff reads many, many publications and then prints a monthly *Selective Index to Health Literature* — and included a *Michigan Medicine* article in its recent Vol. 6, No. 5. Chosen for inclusion was the April article by Willet and others about a health and nutrition study among Michigan Indians.



With QUĪ-A-ZONE — you can sedate effectively. A balanced combination of short, intermediate, and long-acting barbiturates (totaling 100 mg.) in a rapidly disintegrating tablet — sedation is provided within a few minutes . . . followed by sound restful sleep . . . usually without morning hangover. The four barbiturates in QUĪ-A-ZONE have dual channels of elimination (renal and hepatic) to lessen metabolic burden, decrease barbiturate retention, and minimize depression.

QUĪ-A-ZONE™

Each rapidly-disintegrating tablet contains 25 mg. secobarbital, 25 mg. pentobarbital, 25 mg. butabarbital, and 25 mg. phenobarbital. Bottles of 100.
Usual Adult Dose: 1 to 2 tablets before retiring.
PRECAUTION: Should not be administered to patients sensitive to barbiturates, or in cases of known previous addiction. Warning: May be habit forming.

W-C PRECISION PHARMACEUTICALS

SEND FOR SAMPLES.

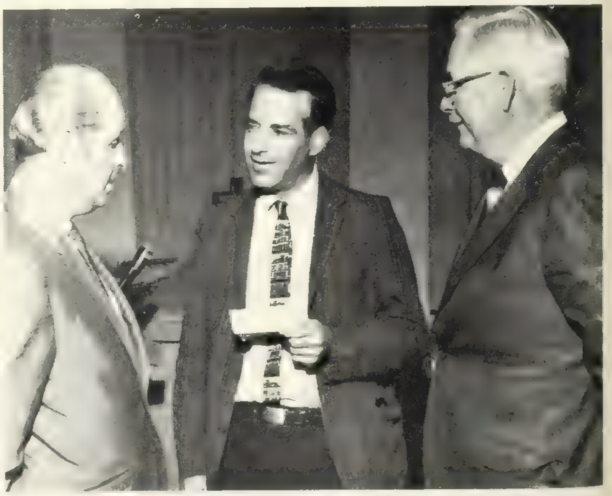
WALKER, CORP & CO., INC.
Syracuse, New York 13201

MSMS Covers State With PG Courses

Escanaba, Battle Creek and St. Joseph were host cities during the most recent series of MSMS-sponsored Postgraduate medical meetings for out-state Michigan doctors. Above, Stuart M. Finch, M.D., professor of psychiatry and chief, Children's Psychiatric Service, University of Michigan, answers questions posed by Berrien County physicians attending the afternoon session of the St. Joseph meeting.

Following the usual pattern, the St. Joseph PG meeting continued with dinner, followed by a formal talk by Doctor Finch, whose topic was "Adolescent Identity Problems." At the head table for the evening program were, from left, Mrs. Dean Asselin, president of the Woman's Auxiliary to the Berrien County Medical Society; Charles E. Payne, M.D., Berrien County society program chairman; Doctor Finch, and Dean K. Ray, M.D., president of the Berrien medical society.

Another of the MSMS-sponsored continuing medical education meetings held twice a year throughout the state was located in Escanaba, where Edwin P. Peterson, M.D., left, assistant professor of obstetrics and gynecology, and Henry R. Swain, M.D., right, professor of pharmacology, both of the U-M Medical School, shared the speakers' table with William A. LeMire, III, M.D., MSMS councilor from Escanaba.



The MSMS postgraduate meetings allow physicians in outlying Michigan to confer with outstanding professors from Michigan's three medical schools. David S. Greenbaum, M.D., center, associate professor of medicine at the College of Human Medicine, MSU, met at the Battle Creek Seminar with William Walters, M.D., left, president of the Calhoun County Medical Society, and Robert M. Leitch, M.D., right, MSMS councilor from the third district.

about doctors

AMONG FACULTY MEMBERS

at the U-M Medical School who were honored at the graduation ceremonies of the 1970 class were three MSMS members. Peter Lynch, M.D., and Thomas Preston, M.D., both assistant professors, received the Senior Award for clinical faculty members who "best fulfill the students' ideal of distinguished medical teaching." A special "surprise" Dean's Award was given to Fred Jenner Hodges, M.D., professor emeritus of radiology.

FREDERICK BOOTHBY, M.D., LAWRENCE,

who retired Aug. 1 after 39 years as the local physician, was paid special tribute by his townspeople in June. They organized a parade from his office on "Dr. Fred Boothby Day" followed by a reception at the high school. Doctor Boothby and his wife will move to Florida.

NED I. CHALAT, M.D., DETROIT,

is one of five U.S. physicians whose comments on treatment of a common ear disease in children are included in the June 15 issue of *Modern Medicine*. His comments appear as a "Forum" article in the national medical journal.

HAROLD FALLS, M.D., ANN ARBOR,

has received the Lucien Howe prize medal for contributions to the general field of ophthalmology. The award was presented at the Annual Scientific Award Dinner during the AMA Convention June 21-25 in Chicago.

STEFAN S. FAJANS, M.D., ANN ARBOR,

is new president-elect of the American Diabetes Association and new vice president of the Endocrine Society. Doctor Fajans is professor of internal medicine at the University of Michigan Medical School.

MELVIN E. FOWLER, M.D., DETROIT,

is the 1970 "Physician of the Year" of the Detroit Medical Society, chosen by his associates "in recognition of his many years of service in private practice and as chief of staff at Kirwood General Hospital."

PAUL W. GIKAS, M.D., ANN ARBOR,

professor of pathology at the University of Michigan, is one of four U.S. physicians whose comments on automobile seat belt injuries are included in the June 1 issue of *Modern Medicine*. The comments appear as a "Forum" feature in the national medical journal.

BENJAMIN F. HADDAD, M.D., GROSSE POINTE,

was named Saint John Hospital's "Man of the Year" at the hospital's 10th annual benefit dinner recently. Doctor Haddad is president of Saint John's medical staff.

WILLIAM N. HUBBARD, M.D., KALAMAZOO,

was the featured speaker at the Area Health Week banquet late in May at Mt. Pleasant. Doctor Hubbard is the former dean of the University of Michigan Medical School and is now vice president of the pharmaceutical division of Upjohn Pharmaceuticals.

TOM M. JOHNSON, M.D., EAST LANSING,

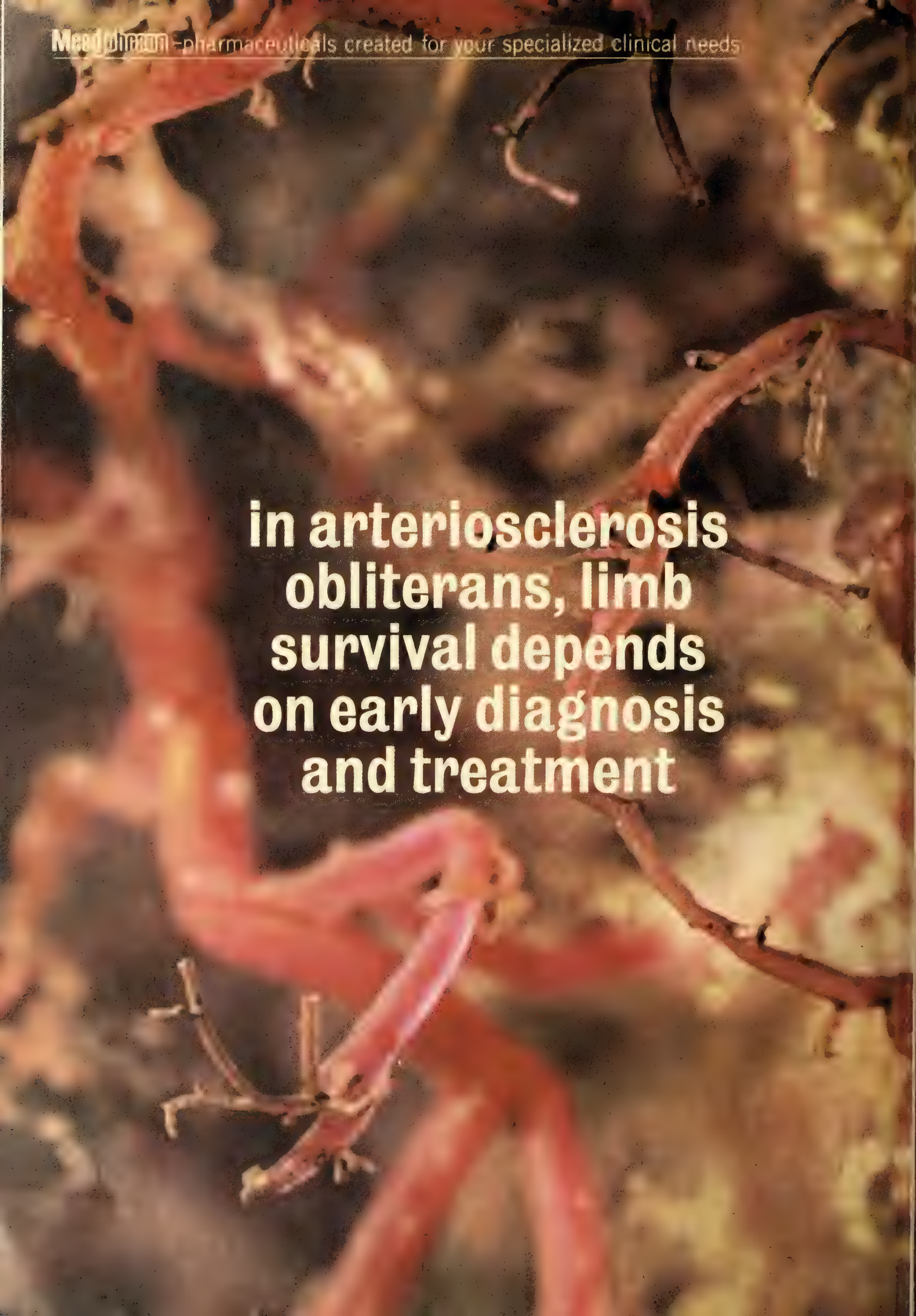
professor of medicine at Michigan State University, received an outstanding faculty award from the graduating medical class in June.

ADRIAN KANTROWITZ, M.D.,

prominent heart surgeon with Maimonides Medical Center in Brooklyn, became the first full-time chief of surgery at Sinai Hospital of Detroit, effective July 1. Doctor Kantrowitz was chief of surgical services at Maimonides Medical Center, and professor of surgery at the Downstate Medical Center of the State University of New York. He is a pioneer in the development of mechanical devices to aid in repairing and sustaining the heart and other vital human organs.

JAMES V. NEEL, M.D., ANN ARBOR,

presented the Albert Lasker Award Lecture May 21 at the Salk Institute for biological studies in La Jolla, Calif., after being named as the recipient of the Albert Lasker Medical Research Award, considered by many as the "American Nobel Prize." Specifically, Doctor Neel reported his eight-year-long genetic study of a tribe of South American Indians. Doctor Neel was also recently elected to the Council of the National Academy of Sciences, and in 1960 received the Albert Lasker Basic Medical Science Research Award.


Mead Johnson -pharmaceuticals created for your specialized clinical needs
in arteriosclerosis obliterans, limb survival depends on early diagnosis and treatment

Microphoto of small artery occlusions in a toe amputated because of severe arteriosclerosis obliterans. Cast was made by injecting acrylic plastic into the vessels. The occluded vessels measure about 30 to 50 microns in diameter. *Used with permission. Courtesy of Margaret C. Conrad, Ph.D., Department of Physiology, Bowman-Gray School of Medicine, Wake Forest College, Winston-Salem, N. C.*

in responsive arteriosclerosis obliterans

VASODILAN®

(ISOXSUPRINE HCl)

- **acts directly to increase blood flow to deep muscle arteries**[1-3]
- **improves walking ability, relieves rest pain**[3-5]
- **may be used safely in patients with peptic ulcer, diabetes or chronic coronary artery disease**[3,6,7]

New 20 mg. strength now available: Vasodilan 20 mg. tablets for greater dosage simplicity and convenience. Recommended *initial* dose: one 20 mg. tablet q.i.d.

lthough not all clinicians agree on the value of peripheral vasodilators,[8-10] several investigators[3,6] have reported favorably on the effects of soxsuprine on peripheral blood flow in skeletal muscle vessels. Effects have been demonstrated both by objective measurement[1,6,11] and bservation of clinical improvement.[3-5,12]

ndications: Arteriosclerosis obliterans, diabetic vascular diseases, thromboangiitis obliterans (Buerger's disease), Raynaud's disease, postphlebitic onditions, acroparesthesia, frostbite syndrome and ulcers of the extremities (arteriosclerotic, diabetic, thrombotic). **Composition:** VASODILAN ablets, isoxsuprine hydrochloride 10 mg. and 20 mg. **Dosage:** Oral—10 to 20 mg. t.i.d. or q.i.d. **Contraindications and Cautions:** There are no nown contraindications to recommended oral dosage. Do not give immediately postpartum or in the presence of arterial bleeding. **Side Effects:** ccasional palpitation and dizziness can usually be controlled by dosage reduction. As intramuscular administration of 10 mg. or more may cause rief hypotension and tachycardia, single intramuscular doses exceeding this amount are not recommended. Complete details available in product rochure from Mead Johnson Laboratories. **References:** (1) Stein, I. D.: Angiology *15*:1 (April) 1964. (2) New Drugs— Evaluated by the A.M.A. Council n Drugs, Chicago, American Medical Association, 1967, pp. 295-297. (3) Kaindl, F.; Pärtan, J., and Polsterer, P.: Wien. lin. Wchnschr. *68*:186-191 (March 16) 1956. (4) Frieh, Ch., and Olivier, L.: Lyon Méd. *91*:891-896 (May 24) 1959. (5) Veghaupt, Von K.: Wien. klin. Wchnschr. *69*:31-32 (Jan. 11) 1957. (6) Kaindl, F.; Samuels, S. S.; Selman, D., and Shaftel, .: Angiology *10*:185-192 (Aug.) 1959. (7) Samuels, S. S., and Shaftel, H. E.: J. Indiana M. A. *54*:1021-1023 (July) 1961. 8) Myers, K. A.: Mod. Treat. *4*:370-383 (March) 1967. (9) Gillespie, J. A.: Angiology *17*:280-288 (May) 1966. (10) Smit, rne, F., *et al.*: Nord. med. *20*:1260, 1959. (11) Samuels, S. S., and Shaftel, H. E.: J.A.M.A. *171*:142-145 (Sept. 12) 959. (12) Clarkson, I. S., and LePere, D. M.: Angiology *11*:190-192 (June) 1960.

MeadJohnson
LABORATORIES

© 1970 MEAD JOHNSON & COMPANY • EVANSVILLE, INDIANA 47721 76170

MAILBAG

Doctor Gamble Comments On MMS Article

To the Editor:

I read with considerable interest your article by Brooker L. Masters, M.D., Fremont, in *Michigan Medicine* regarding Michigan Medical Service.

I know we are getting the blame for Blue Shield prices and it has caused a good deal of discussions here in our area. What most people do not realize is that we have very little control over the hospitals or their charges.

You probably saw the article in the newspapers that stated the cost of a hospital stay twenty years from now will be a thousand dollars. Something has got to be done but on the other hand the congressmen have all raised their salaries, Mr. Nixon has raised his salary and so has almost everyone else in Washington so what can we expect from the unions, etc., when all our leaders tell us to hold down the costs but yet they keep on spending?

Respectfully yours,
W. G. Gamble, Jr., M.D.
Bay City

Doctor Wilcox Labels Pesticide Article 'Misleading'

To the Editor:

The article "A Case of Human Pesticide Poisoning" published in the June 1970 issue of *Michigan Medicine* is extremely misleading. There is not a shred of evidence that this woman suffered from DDT toxicity. At a time when emotional climate makes it difficult to deal objectively with the pesticide problems before us, such articles are unjustified.

One misleading statement concerning the laboratory findings are that cholinesterase levels may be helpful in diagnosing DDT intoxication. Cholinesterase levels are extremely valuable in diagnosing exposure to organophosphate insecticides but are not of value in assessing exposure to DDT. Individuals having frequent exposure to organophosphate insecticides or suspected of having such intoxication, should be evaluated by cholinesterase tests. If DDT intoxication is suspected, determination of blood DDT levels and urine DDA levels can be obtained through the Michigan Department of Public Health.

DDT has the best record of safety of any of the generally used insecticides. The use of DDT has been restricted because it was applied so heavily over the past years that levels in the environment rose to the point that serious effects were being seen in some of our wildlife. It is proper that the use of DDT should now be diminished to the lowest level possible, but it must be kept in mind that many materials substituted for DDT have greater toxic potential for humans. Physicians would do well to consider pesticide intoxication in unexplained, acute illnesses, particularly in children. If such is suspected, reasonable effort should be made to obtain an accurate diagnosis.

Sincerely,
Kenneth R. Wilcox, Jr., M.D.
Associate Director for Laboratory Services
Chief, Bureau of Laboratories

U-M Team Issues Warning On Use of Drug

(Editor's Note: Though MSMS does not have the mechanisms to judge the quality of a particular drug, we reprint the following letter, with its own viewpoint, for your information. We invite Michigan physicians' responses which may be published in the letters to the editor section of forthcoming issues.)

To the Editor,

This letter is to request your consideration of a measure which we believe is in the highest tradition of medicine. We are requesting your participation in trying to prevent the frequent fatalities caused by Glutethimide (Doriden). As physicians caring for a large number of accidental and intentional overdoses at the University of Michigan Medical Center, we feel that Glutethimide is one of the drugs most often involved in fatalities.

The University of Michigan Medical Center has taken steps to delete Glutethimide from our formulary. We feel this deletion justified owing to the frequency of overdoses and the corresponding number of fatalities. Victims of large overdoses of Glutethimide are particularly difficult to treat because of Glutethimide's lack of dialyzability and its lipophilic nature which prolong its toxic effect in the victim.

It is our opinion that Glutethimide's efficacy as a sedative is not sufficiently greater than other less potentially lethal sedatives. The lethal number ingested is sufficiently small when compared to the large number of other sedatives with a larger safety margin and equal efficacy.

We strongly urge Michigan physicians to cease prescribing Glutethimide as a routine sedative; especially in severely depressed patients.

Your concern in bringing this matter to the attention of all Michigan physicians will be appreciated.

Sincerely,
Charles N. Inniss, M.D.
Director, Poison and Adverse Drug Reaction Team
University Hospital
Ann Arbor

MSMS Statement Pleasing to Congressman

To the Editor:

I was very pleased to receive a copy of your very excellent statement on the Family Planning and Population Research Act which appears in the May issue of *Michigan Medicine*.

I share your views on the urgency of the problems relating to family planning, sex education and population control. The AMA is to be congratulated for the leadership role it is taking in this area.

Best personal regards,
William S. Broomfield
Congressman
Michigan's 18th District

Medical Assistants Say 'Thank You' For Journal Articles

To the Editor:

On behalf of all of the medical assistants in Michigan, may I say THANK YOU for the June, 1970 issue of *Michigan Medicine*.

We appreciated the cover photograph commemorating our "Twentieth Year," and your editorial viewpoint on page 538.

We are truly grateful for the support of the Michigan State Medical Society during our first twenty years, and I also wish to thank the staff at headquarters for their cooperation, loyalty and assistance.

Sincerely yours,
(Mrs.) Patricia Austin
President
Michigan State
Medical Assistants Society

Taste!

Dicarbosil®
ANTACID

Your ulcer patients and others will love it. Specify DICARBOSIL 144's—144 tablets in 12 rolls.

ARCH LABORATORIES
319 South Fourth Street, St. Louis, Missouri 63102

Did You Read . . .

important articles in the July issue of **Michigan Medicine** on "The Prevalence of Anemia in Head Start Children," a proposed change in the MSMS constitution to be discussed at the 1970 Annual Session and statements on TB testing and environmental pollution adopted by The MSMS Council.

MSMS Workshop Feature of Triple-Header Meeting

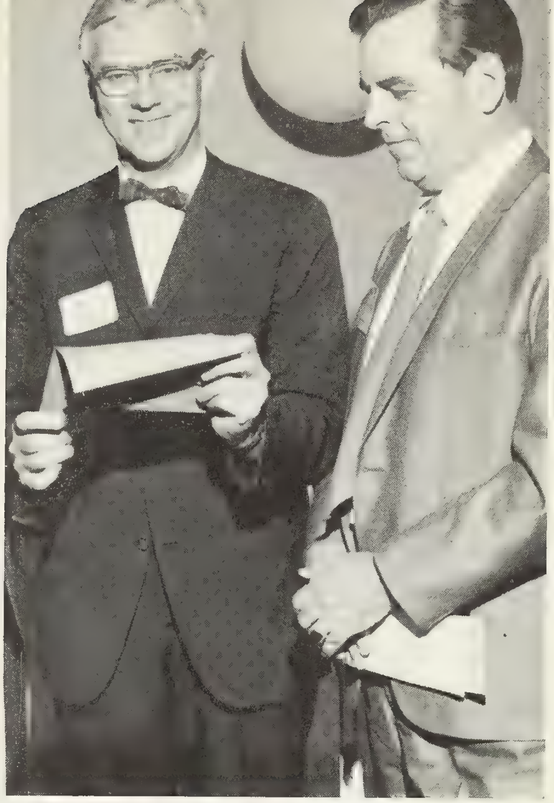
COUNTY MEDICAL SOCIETY presidents, vice presidents, presidents-elect, secretaries and editors were invited to attend the recent MSMS workshop and dinner at MSMS Headquarters to discuss major medical issues. Among those attending were, from left, Joseph E. Cooper, M.D., Van Buren County; Charles E. Black, M.D., Monroe County; Frank A. Merchun, M.D., Ionia County, and Mitchell Urban, M.D., Tuscola County.

MSMS PRESIDENT-ELECT Harold H. Hiscock, M.D., Flint, met with officers of organizations affiliated with MSMS. From left are Mrs. Francis P. Rhoades, Detroit, president-elect, and Mrs. Edward H. Maxim, St. Clair Shores, president of the Woman's Auxiliary to MSMS, and Mrs. Patricia Austin of Ann Arbor, president of the State of Michigan Chapter, American Association of Medical Assistants.

AN MSMS VOLUNTEER LOBBYIST, Fred A. Bryant, M.D., Royal Oak, left, and Washtenaw County Medical Society President George H. Koepke, M.D., Ann Arbor, had a quiet chat during an interlude in the workshop meeting, which included a report on "The Latest on the Chicago-Washington AMA Scene," with an AMA representative.

THE LEADERSHIP WORKSHOP featured roundtable meetings over dinner on the subjects of doctor availability, public relations help, peer review and postgraduate medical education. On hand to take part were from left, D. Bonta Hiscoe, M.D., Lansing; Frank B. Walker, II, M.D., Grosse Pointe; Don W. McLean, M.D., Detroit, and Robert E. Rice, Greenville.

"MD LOBBYISTS Who Came Back" had a spot on the evening program at the workshop. Among those present who gave an account of their experiences, were, from left, Oscar D. Stryker, M.D., Mt. Clemens; Louis R. Zako, M.D., Allen Park; Otto K. Engelke, M.D., Ann Arbor, and William A. De Young, M.D., Saginaw.



The MSMS workshop was part of a two-day triple-header conference for leaders of Michigan medicine sponsored by MSMS, the Michigan Education Association and the Michigan Health Council. The three events were led by a public speaking workshop featuring a national authority, Robert Haakenson, Ph.D., left, of the Department of Public Relations at Smith, Kline and French Laboratories, Philadelphia. He was invited to speak by John A. Doherty, right, executive director, Michigan Health Council.

THE POINT OF VIEW of the plaintiff in a medical malpractice suit was presented by Detroit lawyer Richard M. Goodman, J.D., during a workshop discussion. Others on the panel were, from left, Justin Sleight, M.D., Lansing; Sam W. Thomas, LLB, Detroit; Jack C. Frakes, LLB, Detroit, and Richard Weber, LLB, Detroit, MSMS Legal Counsel's Office.

medical care programs

Doctor Taylor Expresses MSMS Views on CHP

By Herbert Mehler, Staff Assistant
MSMS Committee on
Governmental-Medical Care Programs

MSMS was asked to submit an article about comprehensive health planning in Michigan to be published in an issue of the *State Comprehensive Health Planning News.*

Here are excerpts from the letter written by MSMS Council Chairman Ross V. Taylor, M.D., on June 9, 1970:

"MSMS concurs that the state agency will need to have the confidence of both private and governmental health agencies and that the wide range and special concerns of the many health programs and professional groups must be taken into account if a broadly-based concensus for planning is to be achieved.

"MSMS continues to support comprehensive health planning to the extent that it encourages and can expedite more coordinated and effective community planning for health care facilities.

"MSMS supports the intent of Congress that attainment depends on an effective partnership between government and voluntary effort and participation by individuals and organizations.

"MSMS cautions that any measure taken be without interference with existing patterns of the professional practice of medicine, dentistry and related healing arts.

"MSMS expresses frustration that only three practicing physicians represent the profession on the Advisory Council and that more representation is essential if there is to be partnership and cooperation.

"MSMS recognizes the importance of cooperation between hospitals, supportive health personnel, consumers, and federal and state agencies."

The concluding statement emphasized that this letter was a sincere effort by the doctors of medicine in Michigan to improve and fortify the purposes and objectives enunciated when comprehensive health planning became law.

"Your Society continues to urge physicians to become involved and participate on all community, county or areawide health councils in order that vital medical expertise is provided."

MDPH Announces Three Tests Acceptable For Pre-Marital,-Natal Tests

The Michigan Department of Public Health makes the following announcement to all Michigan physicians:

As of July 1, only the VDRL Slide Test, the RPR (Circle) card test and the FTA-ABS are being accepted by the MDPH as standard serologic tests for syphilis for premarital and prenatal examination purposes. Only those tests will meet the requirements as set forth in Public Acts pertaining to premarital and prenatal testing for syphilis.

PLAINWELL SANITARIUM, INC.

Plainwell, Michigan

M. Leroy Barry, MD

D. W. Everett, MD
W. R. King, PhD

The Plainwell Sanitarium is a private psychiatric hospital licensed by the Michigan Department of Mental Health and accredited by the Joint Commission on Accreditation of Hospitals. Our extensive diagnostic and treatment services include the following:

- Organic and psychological therapy for the psychiatrically and emotionally disturbed of all ages.
- Diagnostic and psychological evaluation and hospitalization, if indicated, of juveniles for courts and social agencies.
- Rehabilitative services for geriatric and convalescent patients.
- Medico-legal counsel.
- Out-patient services.

685-8441 Admissions

685-5952 Out-patients

LEADING MANUFACTURER
INSULIN SYRINGES

B-D

TON, DICKINSON AND COMPANY
HERFORD, NEW JERSEY 07070

FREE CLINICAL SUPPLY

PLASTIPAK
INSULIN SYRINGE/NEEDLE UNITS

Send samples to:

Name ______________________________
(Physician's Signature)

Address ______________________________

City ____________ State ____________ Zip ____________

Clip out postcard on dotted line . . . no stamp required

ow you can lower the risk of nsulin error when your patient is ome . . . and alone

B-D

SINGLE-USE
PLASTIPAK
INSULIN SYRINGE/NEEDLE UNIT

8401
RED CAP u40

8406
GREEN CAP u80

as specific as insulin itself

Postage
will be paid
by
Addressee

No
postage stamp
necessary
if mailed in the
United States

BUSINESS REPLY MAIL
First Class Permit No. 134, Fairview, N.J.

Becton-Dickinson and Company
Consumer Products Division
P.O. Box 183
Fairview, New Jersey 07022

Clip coupon on dotted line . . . fill out other side
send for physician's free samples

THE LEADING MANUFACTUR
OF INSULIN SYRING

B-D

BECTON, DICKINSON AND COMPA
RUTHERFORD, NEW JERSEY 07

color-coded caps and numbers—red for U40, green for U80

presterilized—consistently dependable, and sterility is assured until cap is opened

easy-to-hold, easy-to-handle—even for child diabetics with small hands or adults with stiff fingers

the sharpest needle your patient can buy—far sharper than any reusable needle

pocket-or-purse portable—sturdy from tip to top

integral cannula reduces air bubbles

10
20
30
40
UNITS
10
20
30
40
50
60
70
80
UNITS

single-scale
PLASTIPAK
insulin syringe
needle units
eliminate
the hazard
of reading
the wrong
scale

the first
insulin syringe
so low in cost
your patient
can use
a new one
every time

its single-scale—U40 or U80—minimizes the risk of measurement errors. Your patient *can't* read the wrong scale.

low cost—barely pennies higher than old-fashioned disposable needles without syringe . . . about as low as a cup of coffee

big numbers, wide spaces for easy reading

U40   U80

Supplied: in packages of 10—
PLASTIPAK syringe U-40 (red) or
PLASTIPAK syringe U-80 (green)
Prescription required in most states.

BECTON B-D
DICKINSON
Consumer Products Division
Becton, Dickinson and Company
Rutherford, New Jersey 07070

B-D and PLASTIPAK are trademarks.

Pr

In dermatologic disorders...

the advantages of ALLERSONE OINTMENT in dermatologic disorders

antiinflammatory

▪

antipruritic

▪

antiallergic

▪

anesthetic

IN THE MANAGEMENT of common dermatologic disorders, ALLERSONE provides more than symptomatic relief for your frustrated patient. Because ALLERSONE combines the antiinflammatory, antiallergic and antipruritic action of hydrocortisone with the anesthetic effect of diperodon HCl, it can make a worthwhile contribution to your therapeutic regimen.

ALLERSONE has long provided safe, effective and economical therapy for the anxious patient plagued by dermatologic problems. In addition, it is greaseless, odorless, colorless, as well as washable; thereby assuring a high degree of cosmetic acceptance.

ALLERSONE
OINTMENT
for effective topical management

COMPOSITION: Representing: Hydrocortisone 0.5%; Diperodon Hydrochloride 0.5%; Calamine 2.5%; Zinc Oxide 2.5% in a water-washable base containing sodium lauryl sulfate, propylene glycol, cetyl alcohol, white petrolatum, methylparaben and propylparaben as preservatives and water.

INDICATIONS: Antiinflammatory, antipruritic, and antiallergic preparation with local anesthetic for use in the treatment of atopic dermatitis, dermatitis venenata or contact dermatitis as ivy or oak poisoning, pruritis ani and vulvae (anogenital pruritus), certain allergic skin diseases as infantile eczema, also chronic eczematoid otitis externa, neurodermatitides, intertrigo, as chafing of opposing skin surfaces as on thighs, axilla and below breasts.

ACTION: Hydrocortisone exhibits marked antiinflammatory activity when applied topically to the skin. It is ameliorative in pruritic, allergic and atopic skin lesions. Diperodon hydrochloride is a surface anesthetic, while the calamine and zinc oxide powders are well-known for their mild astringent and protective actions. The remaining ingredients comprise the water-washable base.

DOSAGE AND ADMINISTRATION: Distribute a small amount by gentle application over affected area, two or three times a day; frequency of application to be reduced with improvement.

CONTRAINDICATIONS: Do not apply in the presence of herpes simplex of the eye, chickenpox or other viral diseases or skin tuberculosis; in the presence of a coexisting bacterial infection, an antibacterial agent should be used concurrently.

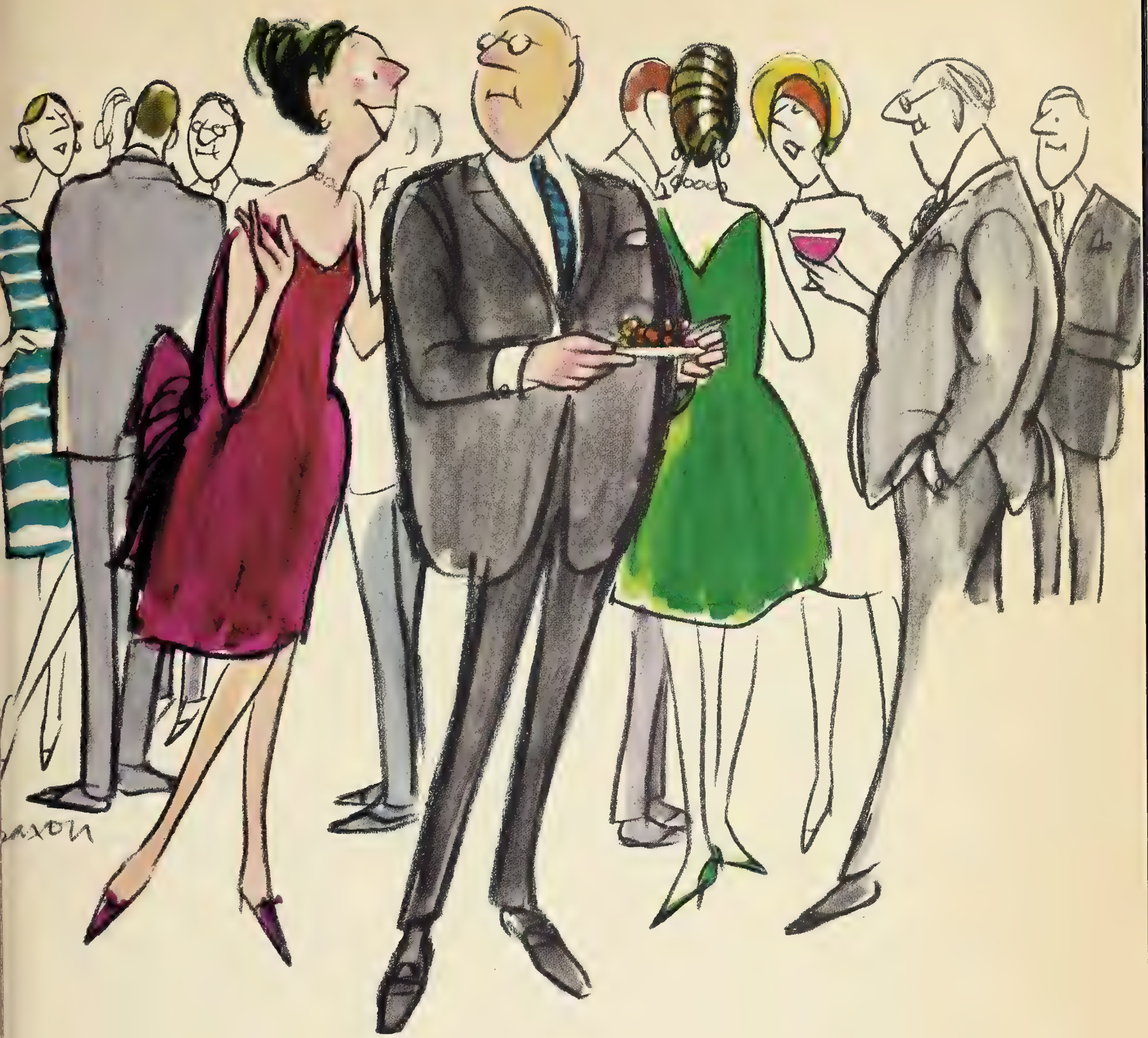
PRECAUTIONS: In rare instances local sensitivity reactions might occur. The safety of the use of topical steroid preparations during pregnancy has not been fully established. Therefore, they should not be used extensively on pregnant patients, in large amounts or for prolonged periods of time.

ADVANTAGES: Contains a local anesthetic which quickly ameliorates pain —while hydrocortisone reduces inflammation—in a water-washable vehicle —no desquamation from fats.

CAUTION: Federal law prohibits dispensing without prescription.

HOW SUPPLIED: 0.90 Allersone, pink ointment, available in 15 Gm. tubes and in pound jars.

MALLARD, INC.
PHARMACEUTICAL MANUFACTURERS
DETROIT, MICHIGAN 48216



ell, Dr. Cunningham! I was just telling Herbert
hould talk to you about my allergy.
rst my nose starts to tickle and…”

know the rest of the story. Sneezing. Watery eyes.
nose. And for prompt relief of these symptoms,
's Novahistine® LP. These continuous-release tablets
a vasoconstrictor-antihistamine formulation that
s working in minutes, then continues to provide
for hours. Even when nasal congestion is due to
ted allergic episodes, two Novahistine LP tablets, morning and evening, let most patients breathe freely all day and all night. Use with caution in individuals with severe hypertension, diabetes mellitus, hyperthyroidism or urinary retention. Caution ambulatory patients that drowsiness may result.

Novahistine® LP decongestant

(Each tablet contains 25 mg. of phenylephrine hydrochloride and 4 mg. of chlorpheniramine maleate.)

DOW THE DOW CHEMICAL COMPANY Rx Pharmaceuticals Indianapolis

Clinical Extension of a pure Smooth Muscle Relaxant

NOTE: *The high therapeutic index of Trocinate permits its administration in dosage sufficient to relieve smooth muscle spasm promptly. 400 mg. dosage usually creates a therapeutic blood level. In reducing dosage after relief, lengthening the time between dosage rather than lessening the recommended dose is preferable. The prompt direct action allows a consciousness of the first suggestion of return of symptom . . . a guide to dose spacing and to determining when treatment is complete. A prescription for twelve or sixteen 400 mg. tablets will usually correct spasm and leave a few tablets for a reserve.*

TROCINATE®

Brand THIPHENAMIL HCl

400 mg./100 mg. S/C tablets

Trocinate relaxes all smooth muscles. Its direct action (musculotropic) does not involve the autonomic nervous system and it is not mydriatic. It is metabolized by the body and eliminated in the urine as harmless degradation products. Trocinate has a remarkable history of freedom from side-effects.

When a pure direct-acting smooth muscle relaxant is indicated, Trocinate is the drug of choice.

DIARRHEA (functional) . . . *the first 400 mg. tablet usually relieves the discomfort of diarrhea so promptly that it ceases to be a bother.*

DIVERTICULITIS—MUCOUS COLITIS *. . . the accompanying discomforts can be relieved by this direct smooth muscle relaxant.*

BLADDER SPASM . . . *relaxation is immediate. One or two tablets condition the bladder for cystoscopy in one hour.*

SPASTIC URETER . . . *the specific relaxing effect of Trocinate on the spastic ureter has been proven by animal studies and affirmed clinically. (J. Urol. 73:487-93)*

PRESCRIBING INFORMATION

WARNING: Do not give in advanced kidney or liver disease. PRECAUTIONS: Trocinate relaxes all smooth muscles. Large dosage or prolonged usage may cause feeling of weakness or can theoretically precipitate gall-bladder colic, due to relaxing the vascular and duct systems. Caution should be observed in patients with urinary bladder obstruction. DOSAGE: 400 mg. May be repeated in 4 hours. After relief, lengthen the dose frequency. (see side note)

WILLIAM P. POYTHRESS & CO., INC.
RICHMOND, VIRGINIA 23217
Manufacturers of Ethical Pharmaceuticals

129 Michigan Communities Seeking G.P.'s; Sixty-Eight Need Specialists

As a service to the people of Michigan and the profession of medicine, the Michigan Health Council conducts the M.D. Placement Program under the guidance of the Michigan State Medical Society.

Inaugurated in 1953, with less than 25 Michigan communities seeking assistance, the program has expanded rapidly as the need for doctors of medicine has grown. The Michigan Health Council currently has 129 communities that are seeking general practitioners.

Medical specialists also are in great demand in Michigan. Sixty-eight Michigan communities now are registered with the Michigan Health Council's Placement Service, some needing only one additional specialist, others seeking several physicians in the same specialty and/or a wide number of medical specialties.

The list of general practitioners and specialists needed appears on the following three pages, in table form, according to the cities needing physicians.

For more information concerning the openings, write or phone: John A. Doherty, Executive Director, Michigan Health Council, P.O. Box 1010, East Lansing 48823, or phone 337-1615.

Specialized Service

IN

PROFESSIONAL LIABILITY INSURANCE

is a high mark of distinction

THE

MEDICAL PROTECTIVE COMPANY

FORT WAYNE, INDIANA

Professional Protection Exclusively since 1899

DETROIT OFFICE: R. K. Wind and J. K. Galloway, Representatives
27200 Lahser Road, Southfield 48075, Telephone: (Area Code 313) ELgin 3-4848 or 444-1439

GRAND RAPIDS OFFICE: G. J. Haworth, Representative
422 Federal Square Building, Grand Rapids 49502 Telephone: 616-454-4477

	General Practice	Allergy	Anesthesiology	Dermatology	Ent	Eent	Immunology	Industrial Med.	Internal Medicine	Ob-Gyn	Occupational Med.	Ophthalmology	Orthopedics-Orthopedic Surg.	Otolaryngology	Otology	Otorhinolaryngology	Pathology	Pediatrics	Public Health	Psychiatry & Neurology	Radiology	Research	Rheumatology	Surgery	Urology	Plastic Surgery
Albion	■								■			■														
Allegan												■						■								
Almont	■																									
Alpena	■								■									■								
Ann Arbor	■			■					■									■								
Armada	■																									
Baldwin	■																									
Bangor	■																									
Baroda	■																									
Barryton	■																									
Battle Creek	■								■											■						
Bay City	■			■					■				■			■		■								
Bear Lake	■																									
Benton Harbor	■								■	■						■		■							■	
Big Rapids	■																									
Brighton	■																									
Buchanan	■																	■								
Burr Oak	■																									
Byron	■																									
Cadillac									■	■								■								
Carson City	■																									
Caseville	■																									
Cass City	■																									
Cedar Springs	■																									
Charlevoix									■																	
Cheboygan	■								■									■								
Chelsea	■																									
Chesaning	■																									
Clinton	■																									
Coldwater	■				■								■											■	■	
Coleman	■																									
Columbiaville — Otter Lake Area	■																									
Crystal	■																									
Crystal Falls	■								■																	
Deckerville	■																									
Detroit	■							■	■	■																
Dowagiac	■																							■		
Edmore and Township	■																									
Emmett	■																									
Empire	■																									
Escanaba	■	■			■				■	■		■			■	■		■							■	
Essexville	■																									
Eureka	■																									
Flint	■																									
Gaylord	■								■																	
Gladwin	■																									
Goodrich	■																							■		
Grand Ledge	■									■																
Grayling	■																									
Greenville	■																			■						
Grosse Pte. Woods	■																									
Hale	■																									

	General Practice	Allergy	Anesthesiology	Dermatology	Ent	Eent	Immunology	Industrial Med.	Internal Medicine	Ob-Gyn	Occupational Med.	Ophthalmology	Orthopedics-Orthopedic Surg.	Otolaryngology	Otology	Otorhinolaryngology	Pathology	Pediatrics	Public Health	Psychiatry & Neurology	Radiology	Research	Rheumatology	Surgery	Urology	Plastic Surgery
Hancock-Houghton	■				■				■	■			■					■		■					■	
Hart	■								■																	
Hastings	■								■									■								
Hillman	■																									
Hillsdale	■								■									■								
Holt	■																									
Holton	■																									
Howell	■																									
Hudson	■								■																	
Iron Mountain	■								■															■		
Ishpeming — Negaunee									■				■					■								
Jackson	■				■				■	■		■	■													
Jenison												■														
Jonesville	■																									
Kaleva	■																									
Kalamazoo	■							■	■	■								■				■		■		
Kent City	■																									
Lakeview	■																									
Lansing—East Lansing	■		■		■				■			■						■		■					■	■
Lapeer	■								■									■								
Lawrence	■																									
Lewiston	■																									
Lexington	■																									
Lincoln	■																									
Litchfield	■																									
Livonia									■																	
Lowell	■																	■								
Mackinac Island	■																									
Mackinaw City	■																									
Mancelona	■																									
Manistee	■				■				■			■	■					■							■	
Marquette	■																			■						
Marshall	■								■									■								
Mason	■																									
Memphis	■																									
Menominee	■																				■			■		
Metamora	■																									
Milan	■																									
Millington	■																									
Monroe	■				■								■	■											■	
Morrice	■																									
Mt. Pleasant	■																	■								
Muskegon	■								■																	
Napoleon	■																									
New Baltimore	■																									
Newberry	■																									
Niles	■					■			■				■													
Northville	■																			■						
Norway	■																									
Onaway	■																									
Ovid	■																									
Owosso	■																	■								

	General Practice	Allergy	Anesthesiology	Dermatology	Ent	Eent	Immunology	Industrial Med.	Internal Medicine	Ob-Gyn	Occupational Med.	Ophthalmology	Orthopedics-Orthopedic Surg.	Otolaryngology	Otology	Otorhinolaryngology	Pathology	Pediatrics	Public Health	Psychiatry & Neurology	Radiology	Research	Rheumatology	Surgery	Urology	Plastic Surgery
Paw Paw	■								■																	
Pigeon	■																									
Plainwell	■																									
Pontiac	■																			■						
Quincy	■																									
Ravenna	■																									
Reading	■																									
Reed City	■																									
Rock	■																									
Rogers City	■																									
Roscommon	■								■																	
Saginaw	■							■	■	■																
St. Clair	■								■																	
St. Helen	■																									
St. Johns	■								■	■								■								
St. Joseph	■								■					■				■		■						
Saline	■																									
Sault Ste. Marie	■				■				■	■		■						■								
Scottville	■																									
Sebewaing	■																									
Shelby	■																									
Sister Lakes	■																									
South Haven	■																								■	
Stephenson	■																									
Sturgis	■																									
Tecumseh-Adrian	■																									
Traverse City	■																			■						
Waldron	■																									
Whitehall	■																									
White Pine	■																									
Zeeland	■								■	■								■								
Chrysler Corporation											■															
Ford Motor Company								■																		
General Motors Corp.								■																		
Local Health Depts.																										
(Statewide) —																										
Alger-Schoolcraft-																										
Luce-Mackinac Assoc.																			■							
Allegan & Van Buren																			■							
Calhoun County																			■							
Jackson County																			■							
Kalamazoo County																			■							
Lenawee County																			■							
Ottawa County																			■							
Thumb District																			■							
Deputy/Asst. Medical																										
Health Officer Positions																										
Berrien County																			■							
Flint-Genesee County																			■							
Totals	129	1	1	2	8	1	0	5	37	12	1	8	0	2	1	3	0	25	10	9	1	1	0	6	8	1

SANDOZ Sandoz announces...

a new agent for
the alcohol-dependent patient
who wants to quit
and
a program for the Michigan physician
who wants to help

When alcohol becomes a way of life
new SERENTIL® (mesoridazine

a major tranquilizer with specific advantages for the alcohol-dependent patien

1. Alleviates tension, anxiety, and depression; may also ease prevalent neurotic symptoms in personality disorders.
2. No reported habituation or addiction.
3. Antiemetic properties to control nausea and vomiting.
4. Has not caused hepatic dysfunctio or interfered with functional reco ery of impaired liver.
5. Four tablet strengths to allow flexibi ity of dosage (usual starting dose for the problem drinker, 10 mg. t.i.d. for the frank alcoholic, 25 mg. b.i.d.
6. Injectable form available for acut episodes.

program for early recognition and successful treatment:

Alcoholism in Michigan*

	State Rank
total no. alcoholics	6th
no. per capita	11th
per capita consumption†	15th

Michigan Physicians' Report
(compared with U.S. average)

	%Mich.	%U.S.
see 5 or more problem drinkers in 2-month period	44.4	37.1
half or more seen are women	29.9	37.4
treat, rather than refer	68.8	72.6
more community services needed	63.1	63.0

*based on preliminary data supplied by Center of Alcohol Studies, Rutgers Univ. †absolute alcohol

The Ins-and-Outs of Alcoholism: A series of recordings and other mailings, each concerned with a particular aspect of the alcohol problem. Recognized authorities in the field discuss the scope, recognition and treatment of alcohol-dependent patients. Also included will be **The Alcoholic Directory,** a nationwide survey of treatment centers.

Interested? Complete and mail this coupon to:

Dept. SERENTIL/Sandoz Pharmaceuticals
Route 10/Hanover, N. J. 07936

SANDOZ

Dr.______________________________
(PLEASE PRINT)

Street______________________________

City________________ State__________ Zip__________

The Alcoholic Directory

See next page for prescribing information.

INDICATIONS: In clinical studies, Serentil (mesoridazine) has been found useful in the following disease states:

Alcoholism—Acute and Chronic: Serentil ameliorates anxiety, tension, depression, nausea and vomiting in both acute and chronic alcoholics without producing hepatic dysfunction or hindering the functional recovery of the impaired liver.

Schizophrenia: Serentil is effective in the treatment of schizophrenia. It substantially reduces the severity of Emotional Withdrawal, Conceptual Disorganization, Anxiety, Tension, Hallucinatory Behavior, Suspiciousness and Blunted Affect in schizophrenic patients. As with other phenothiazines, patients refractory to previous medication may respond to Serentil.

Behavioral Problems in Mental Deficiency and Chronic Brain Syndrome: The effect of Serentil was found to be excellent or good in the management of hyperactivity and uncooperativeness associated with Mental Deficiency and Chronic Brain Syndrome.

Psychoneurotic Manifestations: Serentil reduces the symptoms of anxiety and tension, prevalent symptoms often associated with neurotic components of many disorders, and benefits personality disorders in general.

CONTRAINDICATIONS: As with other phenothiazines Serentil (mesoridazine) is contraindicated in severe central nervous system depression or comatose states from any cause. Serentil is contraindicated in individuals who have previously shown hypersensitivity to the drug.

WARNINGS: Where patients are participating in activities requiring complete mental alertness (e.g., driving), it is advisable to administer the phenothiazines cautiously and to increase the dosage gradually.

Usage in pregnancy: The safety of this drug in pregnancy has not been established; hence, it should be given only when the anticipated benefits to be derived from treatment exceed the possible risks to mother and fetus.

Usage in children: The use of Serentil in children under 12 years of age is not recommended, because safe conditions for its use have not been established.

Attention should be paid to the fact that phenothiazines are capable of potentiating central nervous system depressants (e.g., anesthetics, opiates, alcohol, etc.) as well as atropine and phosphorus insecticides.

PRECAUTIONS: While ocular changes have not to date been related to Serentil, one should be aware that such changes have been seen with other drugs of this class.

Because of possible hypotensive effects, reserve parenteral administration for bedfast patients or for acute ambulatory cases, and keep patient lying down for at least ½ hour after injection.

Leukopenia and/or agranulocytosis have been attributed to phenothiazine therapy. A single case of transient granulocytopenia has been associated with Serentil (mesoridazine).

ADVERSE REACTIONS: Drowsiness and hypotension were the most prevalent side effects encountered. Side effects tended to reach their maximum level of severity early with the exception of a few (rigidity and motoric effects) which occurred later in therapy.

SERENTIL®
(mesoridazine)
new weapon
in the fight against
alcoholism

With the exceptions of tremor and rigidity, adverse reactions were generally found among those patients who received relatively high doses early in treatment. Clinical data showed no tendency for the investigators to terminate treatment because of side effects.

Serentil has demonstrated a remarkably low incidence of adverse reactions when compared with other phenothiazine compounds.

Central Nervous System: Drowsiness, Parkinson's syndrome, dizziness, weakness, tremor, restlessness, ataxia, dystonia, rigidity, slurring, akathisia, motoric reactions (opisthotonos) have been reported.

Autonomic Nervous System: Dry mouth, nausea and vomiting, fainting, stuffy nose, photophobia, constipation and blurred vision have occurred in some instances.

Endocrine System: Inhibition of ejaculation and lactation have been noted rarely.

Skin: Itching, rash, hypertrophic papillae of the tongue and angioneurotic edema have been reported.

Cardiovascular System: Hypotension and tachycardia have been reported. EKG changes have occurred in some instances (see Phenothiazine Derivatives: Cardiovascular Effects).

Phenothiazine Derivatives: It should be noted that efficacy, indications and untoward effects have varied with the different phenothiazines. The physician should be aware that the following have occurred with one or more phenothiazines and should be considered whenever one of these drugs is used:

Autonomic Reactions: Miosis, obstipation, anorexia, paralytic ileus.

Cutaneous Reactions: Erythema, exfoliative dermatitis, contact dermatitis.

Blood Dyscrasias: Agranulocytosis, leukopenia, eosinophilia, thrombocytopenia, anemia, aplastic anemia, pancytopenia.

Allergic Reactions: Fever, laryngeal edema, angioneurotic edema, asthma.

Hepatotoxicity: Jaundice, biliary stasis.

Cardiovascular Effects: Changes in the terminal portion of the electrocardiogram, including prolongation of the Q-T interval, lowering and inversion of the T-wave and appearance of a wave tentatively identified as a bifid T or a U wave have been observed in some patients receiving the phenothiazine tranquilizers, including Serentil (mesoridazine). To date, these appear to be due to altered repolarization and not related to myocardial damage. They appear to be reversible. There is no evidence at present that these changes are in any way precursors of any significant disturbance of cardiac rhythm.

Hypotension, rarely resulting in cardiac arrest has been noted.

Extrapyramidal Symptoms: Akathisia, agitation motor restlessness, dystonic reactions, trismus torticollis, opisthotonos, oculogyric crises, tremor muscular rigidity, akinesia—some of which on rare occasions have persisted for several months or years especially in patients of advanced age with brain damage.

Endocrine Disturbances: Menstrual irregularities altered libido, gynecomastia, weight gain. False positive pregnancy tests have been reported.

Urinary Disturbances: Retention, incontinence.

Others: Hyperpyrexia. Behavioral effects suggestive of a paradoxical reaction have been reporte These include excitement, bizarre dreams, aggr vation of psychoses and toxic confusional states More recently, a peculiar skin-eye syndrome has been recognized as a side effect following long term treatment with phenothiazines. This reaction is marked by progressive pigmentation of areas of the skin or conjunctiva and/or accompanied by discoloration of the exposed sclera and cornea Opacities of the anterior lens and cornea de scribed as irregular or stellate in shape have also been reported.

DOSAGE AND ADMINISTRATION: Oral: The do age of Serentil (mesoridazine), as in most med cations, should be adjusted to the needs of the individual. The lowest effective dosage should always be used. When maximum response i achieved, dosage may be reduced gradually to a maintenance level.

Alcoholism: For most patients the usual starting dose is 25 mg. b.i.d. The usual optimum tota daily dose range is 50-200 mg. per day.

Schizophrenia: For most patients, regardless o severity, a starting dose of 50 mg. t.i.d. is recor mended. The usual optimum total daily dose rang is 100-400 mg. per day.

Behavioral Problems in Mental Deficiency an Chronic Brain Syndrome: For most patients a sta ing dose of 25 mg. t.i.d. is recommended. Th usual optimum total daily dose range is 75-300 m per day.

Psychoneurotic Manifestations: For most patients th usual starting dose is 10 mg. t.i.d. The usual op mum total daily dose range is 30-150 mg. per da

Injectable Form: In those situations in which a intramuscular form of medication is indicate Serentil (mesoridazine) Injectable is available. Fo most patients a starting dose of 25 mg. is reco mended. The dose may be repeated in 30 to 6 minutes, if necessary. The usual optimum total dai dose range is 25-200 mg. per day.

HOW SUPPLIED: Tablets: 10 mg., 25 mg., 50 mg and 100 mg. mesoridazine (as the besylate). Bo tles of 100.

Ampuls: 1 cc. [25 mg. mesoridazine (as the bes ate)]. Inactive ingredients—Disodium Edeta U.S.P., 0.5 mg.; Sodium Chloride, U.S.P., 7.2 mg Carbon Dioxide Gas (Bone Dry), q.s.; Water fo Injection, U.S.P., q.s. to 1 cc. Boxes of 20 and 10

SER70-101

Sandoz Pharmaceuticals, Hanover, N.J.

medico-legal

(Editor's Note: The following articles are quoted from the AMA CITATION newsletter of Feb. 1, 1970, prepared by the AMA Law Department. Though the court cases did not take place in Michigan, they are reprinted here at the suggestion of scientific editor John W. Moses, M.D., Detroit, with accompanying comment.)

One of the reasons for malpractice suits is the injudicious use of physician criticism of other physicians. No physician should criticize others without a complete picture and review of the situation. The following article points out the problem.

John W. Moses, M.D.

AVOIDING MALPRACTICE SUITS

Reasons for the unprecedented increase in the filing of medical malpractice claims, and suggestions on how to avoid such suits, are discussed in a recent law review article.

The author states that 10,000 malpractice cases are filed every year against doctors, with jury verdicts reaching as high as the $1,500,000 recently awarded to a paralyzed anesthesia mishap victim. Surveys show that one out of six practicing physicians has had at least one malpractice claim made against him and that 57.7 per cent of the doctors reporting carried only $50,000 to $100,000 malpractice policies. Therefore, it is essential that the medical profession be made aware of the current problems in malpractice litigation.

One of the major reasons for the increase in malpractice suits is the criticism by physicians of the work of their colleagues. The AMA has repeatedly warned against such destructive criticism, which gives ideas to an increasingly lawsuit-minded public.

Medical and legal television shows dealing with this subject have also made the viewing public malpractice conscious, and the author would like to have scripts dealing with doctors carefully screened in advance of their showing. He also warns against the thoughtless leaving in waiting rooms of medical journals containing malpractice articles.

One way a doctor can avoid being sued for malpractice is to establish and continue a good patient-physician relationship, frankly discussing

Lectro -pads
Lectro -pads
They work best together!

BURDICK ELECTROCARDIOGRAPHS AND BURDICK ECG SUPPLIES

The electrocardiogram must be diagnostically accurate and clear in every detail because it is a permanent record of the patient's condition. The Burdick EK 4 is designed to give you this accuracy and dependable service-free performance. To insure this, use only supplies designed specifically to work with Burdick ECG equipment. Burdick EK 10 paper is designed so that paper coating will not be picked up to distort accuracy or shorten stylus life. EK-19 Lectro-pads offer neat, quick electrode applications. Burdick ECG mounts facilitate filing of patient records.

Remember — your cardiograph is only as good as the accessories you use with it. Ask your Burdick dealer about the EK 4 and our complete line of ECG supplies, or write **The Burdick Corporation, Milton, Wisconsin 53563** for further details and technical information.

BURDICK

THE G. A. INGRAM COMPANY
4444 Woodward Avenue, Detroit, Michigan 48201
Telephone: TEmple 2-4444

the possibility of a bad result in the case before beginning treatment or surgery.

Since the winning of a malpractice lawsuit gains newspaper, television and radio coverage and encourages the filing of similar suits, the author would like to see greater percentage of meritorious cases settled out of court. This could be achieved by having local medical society groups set up "malpractice screening committees" to review charges of malpractice before they get into the courts. If the committee is convinced after a hearing that malpractice has been committed it is then in a position to offer medical testimony for the patient in the courts if the case is not promptly settled out of court.

Another solution to the rising rate of malpractice litigation is to include in the consent forms for hospital and surgical use an arbitration clause requiring that a physician, a lawyer and an experienced scientific man, or the American Arbitration Association, be named to arbitrate any alleged malpractice disputes between patient and doctor or hospital. The removal of such cases from the courts would also result in a fairer determination, since the jurors' emotions and lack of professional background in medicine or surgery would not influence the final decision. — *RX for Malpractice,* by Albert Averbach, 19 Cleveland State Law Review No. 1, p. 20 (January, 1970), published by Cleveland-Marshall College of Law, 1240 Ontario St., Cleveland, Ohio 44113.

from Vol. 20, No. 8

This opinion points out how the physician should be aware of the possible difficulties he may encounter in similar situations.

John W. Moses, M.D.

EXAM CREATES PHYSICIAN-PATIENT RELATIONSHIP

In a suit to invalidate a will, the court held inadmissible a physician's testimony as to the mental and physical condition of the decedent, a Christian Scientist. The physician had conducted the examination required for the decedent's admission to a nursing home. His testimony should not have been admitted in evidence, an Indiana Appellate court ruled, because the examination was "professional business" within the meaning of the physician-patient privilege statute.

The decedent was an elderly widower. In the fall of 1961, he suffered a virus infection which curtailed his activities. Since he practiced the Christian Science faith, he refused medical aid during the illness.

In February, 1962, the decedent executed his will.

In March, 1962, he applied for admission to a nursing home. He was told that a physician's approval was necessary for admission. The decedent called the physician, who was an old friend, but who had not treated him since the decedent had become a Christian Scientist 25 years earlier. The physician examined him and filled out the home's admission form. The decedent lived little more than a month after his admission to the home. The cause of death was arteriosclerosis.

The privilege statute provides that a physician is not a competent witness as to matters communicated to him in the course of his professional business or as to his advice given in such a case.

The proponents of the will contended that the physician's testimony should not have been admitted because although he acted in his professional capacity in making the examination, he was not in a physician-patient relationship. They argued that a physician-patient relationship required a more intimate contact than that which occurred in the physician's performance of the utilitarian service that was involved here.

"Professional business" as used in the statute means any contact between a physician and a patient in the course of which the physician is required to make some evaluation, perform some duty, or do some act based on his medical expertise which is to benefit the patient. The resolution of the requirement is made on a qualitative, rather than on a quantitative, basis. The physician performed a duty that required a medical doctor and, in doing so, he was working for the direct benefit of the decedent. He was therefore incompetent to testify as to information gained in the course of the examination. — *Vaughan v. Martin,* 251 N.E.2d 444 (Ind., Oct. 15, 1969)

from Vol. 20, No. 8

Don't Miss . . .

the many important articles on the 1970 Annual Session coming next in the September issue of **Michigan Medicine.** Detailed information on the House of Delegates and Scientific Session meetings Sept. 20-24 at the Sheraton-Cadillac Hotel, Detroit, including times, places, speakers and topics.

EVERY WOMAN WHO'S LOVED...

will appreciate this advice from you

Many women find they occasionally have excessive discharge, spotting and increased mucus secretion, which can result in unpleasant odor. Douching with StomAseptine cleanses, deodorizes, soothes and relieves itching . . . and helps prevent embarrassment. Your recommendation of a regular program of StomAseptine douching will do wonders for a woman's self-assurance and peace of mind.

STOMASEPTINE®
DOUCHE POWDER

cleanses internally
deodorizes thoroughly

StomAseptine provides sodium perborate, sodium bicarbonate, sodium chloride, sodium borate, menthol, thymol, eucalyptol, methyl salicylate and aromatics.

HARCLIFFE LABORATORIES, Inc.
423 Atlantic Avenue, Brooklyn, N.Y. 11217

Environment and Health Topics of Doctor Reizen's, Doctor Isbister's Talks

(The following remarks were made at the recent Environmental Teach-Out to the Greater Lansing Medical Community, sponsored by the MSU chapter of the Student American Medical Association. The teach-out, entitled "Physician Responsibility in Environmental Health Care Delivery," took place on the MSU campus.)

By Maurice S. Reizen, M.D., Director
Michigan Department of Public Health

My concern is that of overcrowding and over population — its psychological and social implications. Being neither a psychologist nor a sociologist, I should be in a good position to pontificate on the subject. And in addition, you might just understand me.

Is this population explosion really a problem? — Yes!

The human factor is part of the ecological life system. We are terribly interdependent upon one another and upon other systems. The reciprocal relations between the physical environment and biological communities are the essence of ecology.

And we are running out of food.

We are running out of fossil fuels.

We are running out of chlorophyll producing plants.

We have seen the relationship between overcrowding and crime, drugs, anti-social behavior and hunger.

Is this important for the U.S. and other developed countries? — Yes, because the baby boom is here. Also, the relationship of the birth rate to the death rate is important.

Our solution is either to up the death rate or to lower the birth rate. The first is usually not acceptable; therefore, the only alternative is population control. (But we do legalize murder in war and capital punishment.)

What can physicians do?

We can (1) acknowledge this is a problem for us; (2) attempt to divorce the problem from emotional bias; (3) encourage population control from our offices, hospitals, homes and in the political arena; (4) remove archaic restrictions, legal, traditional or cultural, when feasible; (5) revise our national priorities so that first things come first, i.e., more mass transit instead of more highways and autos, fewer fertilizers with high nitrogen and phosphates which increase water pollution and decreased electrical power to decrease the amount of CO^2, SO^2 and soot; (6) encourage research in population control, so that we can approach the ideal technique for family planning, and (7) back Family Planning and Planned Parenthood associations.

By John L. Isbister, M.D., Chief
Bureau of Community Health
Michigan Department of Public Health

(Editor's Note: The following article is excerpted from a talk delivered recently by Doctor Isbister at a Michigan State University Environmental Teach-In for physicians. It is another item on the environment and health, published according to the wishes of the MSMS Committee on Public Health.)

When confronted with a patient whose illness seems not to follow any of the usual and customary patterns or which presents a baffling picture as to the probable cause, the physician must think of the possibility of environmental factors.

Many of the chemical compounds which our technology has developed are capable of producing a profound and sometimes bizarre effect on those who are exposed to them. An increased awareness that this may be occurring with one of his patients will frequently assist the physician in running down a particular illness.

Very often the public health department can be of material help to the physician in these situations. Calling upon it for assistance, he will sometimes find that other physicians have reported the same or a similar situation in their practices and each new report helps in following out the epidemiology.

The local health department can, when necessary, call on skilled personnel from both the state and federal health services to assist in environmental investigations. These experts include epidemiologists, engineers, biologists, chemists, industrial physicians and others skilled in particular scientific areas but also exceedingly well oriented in the relationship of the environment to the individual as a factor in health and illness.

Frequently, the discovery that a particular substance or environmental factor can cause illness results in measures which modify the agent or the circumstances under which it is used so that disease is prevented and this is, after all, a basic consideration in medicine.

There are numerous incidents illustrating that the usual environment of the patient may contribute to illness. Irrespective of how unlikely it may appear, the physician can do well to keep the possibility in the back of his mind, particularly when dealing with an illness which seems not to follow the usual pattern.

The girth control pill

Tepanil® Ten-tab

(continuous release form)

(diethylpropion hydrochloride)

works on the appetite not on the 'nerves'

When girth gets out of control, TEPANIL can provide sound support for the weight control program you recommend. TEPANIL reduces the appetite—patients enjoy food but eat less. Weight loss is significant—gradual—yet there is a relatively low incidence of CNS stimulation.

Contraindications: Concurrently with MAO inhibitors, in patients hypersensitive to this drug; in emotionally unstable patients susceptible to drug abuse.

Warning: Although generally safer than the amphetamines, use with great caution in patients with severe hypertension or severe cardiovascular disease. Do not use during first trimester of pregnancy unless potential benefits outweigh potential risks.

Adverse Reactions: Rarely severe enough to require discontinuation of therapy, unpleasant symptoms with diethylpropion hydrochloride have been reported to occur in relatively low incidence. As is characteristic of sympathomimetic agents, it may occasionally cause *CNS effects* such as insomnia, nervousness, dizziness, anxiety, and jitteriness. In contrast, CNS depression has been reported. In a few epileptics an increase in convulsive episodes has been reported. Sympathomimetic *cardiovascular effects* reported include ones such as tachycardia, precordial pain, arrhythmia, palpitation, and increased blood pressure. One published report described T-wave changes in the ECG of a healthy young male after ingestion of diethylpropion hydrochloride; this was an isolated experience, which has not been reported by others. *Allergic phenomena* reported include such conditions as rash, urticaria, ecchymosis, and erythema. *Gastrointestinal effects* such as diarrhea, constipation, nausea, vomiting, and abdominal discomfort have been reported. Specific reports on the hematopoietic system include two each of bone marrow depression, agranulocytosis, and leukopenia. A variety of miscellaneous adverse reactions have been reported by physicians. These include complaints such as dry mouth, headache, dyspnea, menstrual upset, hair loss, muscle pain, decreased libido, dysuria, and polyuria.

Convenience of two dosage forms: TEPANIL Ten-tab tablets: One 75 mg. tablet daily, swallowed whole, in midmorning (10 a.m.); TEPANIL: One 25 mg. tablet three times daily, one hour before meals. If desired, an additional tablet may be given in midevening to overcome night hunger. Use in children under 12 years of age is not recommended.

T-006A / 1/70 / U.S. PATENT NO. 3,001,910

THE NATIONAL DRUG COMPANY
DIVISION OF RICHARDSON-MERRELL INC
PHILADELPHIA, PENNSYLVANIA 19144

Painful night leg cramps...

unwelcome bedfellow for any patient— including those with arthritis, diabetes or PVD

One thing patients can sleep without, particularly patients with chronic disease conditions such as arthritis, diabetes or PVD, is painful night leg cramps. Although seldom the presenting complaint, night leg cramps can tie your patients up in painful knots. Now, just one tablet of QUINAMM at bedtime can usually bring an end to shattered sleep and needless suffering. Your patients will sleep restfully—gratefully—with QUINAMM, specific therapy to prevent painful night leg cramps.

Prescribing Information—Composition: Each white, beveled, compressed tablet contains: Quinine sulfate, 260 mg., Aminophylline, 195 mg. **Indications:** For the prevention and treatment of nocturnal and recumbency leg muscle cramps, including those associated with arthritis, diabetes, varicose veins, thrombophlebitis, arteriosclerosis and static foot deformities. **Contraindications:** QUINAMM is contraindicated in pregnancy because of its quinine content. **Precautions/Adverse Reactions:** Aminophylline may produce intestinal cramps in some instances, and quinine may produce symptoms of cinchonism, such as tinnitus, dizziness, and gastrointestinal disturbance. Discontinue use if ringing in the ears, deafness, skin rash, or visual disturbances occur. **Dosage:** One tablet upon retiring. Where necessary, dosage may be increased to one tablet following the evening meal and one tablet upon retiring. **Supplied:** Bottles of 100 and 500 tablets.

THE NATIONAL DRUG COMPANY
DIVISION OF RICHARDSON-MERRELL INC.
PHILADELPHIA, PENNSYLVANIA 19144

Quinamm™ Specific therapy for night leg cramps
(quinine sulfate 260 mg., aminophylline 195 mg.)

Q915A

Schering

After only one year:

Administered to more people than live in Grand Rapids.*

Injectable
Garamycin®
brand of
gentamicin sulfate injection

*An estimated 208,000 patients have received GARAMYCIN Injectable to date. The population of Grand Rapids is 205,000. (Estimated 1969 figure from The New York Times Encyclopedic Almanac 1970.)

See Clinical Considerations section on last page...

Schering

Injectable Garamycin®
brand of
gentamicin sulfate injection

ADULT DOSAGE GUIDELINES
See definitive prescribing information in Package Insert.

Patients with Normal Renal Function

Total Daily Dose (administered in two, three, or four divided doses)			
	Less Severe	**Resistant/ Moderately Severe**	**Serious/ Life-Threatening**
Urinary Tract Infections (due to susceptible strains of gram-negative bacteria)†	0.8-1.2 mg./kg. for 7-10 days	Larger doses or additional antibacterial therapy should be considered in severe urinary tract infections or in resistant cases involving the renal parenchyma or anatomic anomaly.	up to 5 mg./kg.
Other Infections including bacteremia, infected surgical wounds, severe soft tissue infections, and respiratory tract infections (due to susceptible strains of gram-negative bacteria)	3 mg./kg. for 7-10 days		

†Alkalinization of the urine may be a useful therapeutic adjunct.

Patients with Impaired Renal Function
To minimize the risk of ototoxicity in patients with impaired kidney function, only the first dose should be that normally recommended. Each subsequent dose should be half or less of that recommended for patients with normal renal function, depending upon the degree of renal impairment.

In patients with renal failure who are undergoing 14-hour hemodialysis twice weekly, administration of 1 mg./kg. GARAMYCIN Injectable at the end of each dialysis period has been suggested.

Clinical Considerations

Indications: GARAMYCIN Injectable is clinically effective in infections due to susceptible strains of gram-negative bacteria, including *Pseudomonas aeruginosa,* and species of indole-positive and indole-negative *Proteus, Escherichia coli,* and *Klebsiella-Aerobacter.* Bacteriologic studies should be conducted to identify the causative organism and to determine its sensitivity to gentamicin sulfate. Sensitivity discs of the drug are available for this purpose. If the susceptibility tests indicate that the causative organism is resistant to gentamicin sulfate, other appropriate antibiotic therapy should be instituted.

IN VITRO INHIBITION OF CLINICALLY IMPORTANT BACTERIA BY GENTAMICIN SULFATE (TUBE DILUTION STUDIES)

BACTERIA	No. of Strains Tested	No. of Strains (%) Inhibited by: 4 mcg./cc. or less		8 mcg./cc. or less*		No. of *In Vitro* Studies
Staphylococcus aureus	1,210	1,200	(99%)	1,206	(99%)	11
Pseudomonas aeruginosa	885	771	(87%)	828	(93%)	16
Escherichia coli	836	736	(88%)	779	(93%)	11
Indole-positive and indole-negative *Proteus* species	477	210	(44%)	358	(75%)	12
Klebsiella-Aerobacter species	292	205	(70%)	231	(79%)	10

*Number of strains (%) of gram-negative bacteria inhibited by 10 mcg./cc. or less are as follows: *Pseudomonas aeruginosa,* 828 (93%); *Escherichia coli,* 792 (95%); *Proteus* species, 393 (82%); *Klebsiella-Aerobacter* species, 284 (97%). From same studies as above.
Source: Package Insert

This drug should be limited to the treatment of serious infections caused by gram-negative bacteria, particularly *Pseudomonas aeruginosa, Proteus* and other susceptible organisms, with due regard for relative antibiotic toxicity. Therefore, the drug should be considered for use against gram-negative: 1. Bacteremia; 2. Infected surgical wounds; 3. Severe soft tissue infections, including burns complicated by sepsis; 4. Respiratory tract infections; and 5. Selected cases of urinary tract infection.

Contraindications: GARAMYCIN Injectable is contraindicated in i dividuals with a history of hypersensitivity or toxic reactions gentamicin.

Warnings: Patients receiving treatment with GARAMYCIN should be under close clinical observation because of the toxicity associated with the use of this drug. Ototoxicity, vestibular and auditory, can occur in patients, primarily those with preexisting renal damage, treated with GARAMYCIN Injectable, usually for longer periods or with higher doses than recommended.

GARAMYCIN Injectable is potentially nephrotoxic, and this should be kept in mind when it is used in patients with preexisting renal impairment. Kidney function diminished by infection of the upper urinary tract may, however, improve during effective treatment with GARAMYCIN Injectable.

Concurrent administration of potentially ototoxic drugs such as streptomycin and kanamycin or of potentially nephrotoxic drugs such as polymyxin, colistin, and kanamycin with gentamicin sulfate has not been shown to afford any clinical advantages and, moreover may result in additive toxicity. Monitoring of vestibular, cochlear, and renal function will provide guidance for therapy in such cases.

Precautions: In patients with impaired renal function in who serious infection develops, serum concentrations of the drug ma rise, with consequently increased risk of ototoxicity. In these pa tients or in those in whom recommended dosage or duration therapy must be exceeded as a life-saving measure, routine studi of kidney function should be performed when possible. These ma be supplemented by evaluation of the vestibular and auditory fun tion and measurement of serum concentration of the drug whe feasible. Serum concentrations of gentamicin should be maintaine below the range of 10-12 mcg./ml. to reduce risk of ototoxicity.

Ordinarily, treatment should not be given for more than 7 to 1 days or be repeated unless required for serious infection not r sponsive to other agents.

As with other antibiotics, treatment with GARAMYCIN Injectab may occasionally result in overgrowth of nonsensitive organisms. superinfection occurs, appropriate therapy is indicated.

Safety for use in pregnancy or the potential for fetal ototoxicity nephrotoxicity have not been established. Studies in pregnant an mals have not revealed teratogenic or ototoxic effects in the fetu GARAMYCIN Injectable should not be used in pregnant patients in women of childbearing age unless its use is deemed advisab by the physician.

Adverse Reactions: The overall incidence of ototoxicity considere related to treatment with GARAMYCIN Injectable was 2.8 per ce (16 of 565 patients). Contributory factors (two or more factors we relevant to most patients) were as follows: 10 had azotemia, 1 received a total of 1 gram or more of the drug, 7 had recently r ceived other potentially ototoxic antibiotics (streptomycin or kan mycin), and 5 were over 60 years of age. Six also had decrease high-tone hearing acuity, which returned to or toward normal i the 4 patients retested.

Analysis of BUN data indicated that 4 (2%) of 172 patients showe increases in BUN that were probably related to treatment wi GARAMYCIN Injectable. Of 20 increases probably or possibly relat to treatment, 7 were reversible, 9 occurred in terminal patients, an 4 had no follow-up.

Other adverse reactions associated with treatment were one instan each of urticaria, decreased hematocrit, and reversible depressi of granulocytes with normal bone marrow. Other rarely report and possibly treatment-related adverse reactions were anemia, i creased reticulocyte count, rash, purpura, drug fever, hypotensio convulsions, twitching, salivation, nausea, vomiting, increased tran aminase activity (SGOT or SGPT), increased serum bilirubin, d creased serum calcium, and joint pain.

Packaging: GARAMYCIN Injectable, 40 mg./cc., 2-cc. multiple-do vials, for intramuscular administration.

For more complete prescribing details, consult package insert Physicians' Desk Reference. Schering literature is also availab from your Schering Representative or Medical Services Departmen Schering Corporation, Union, New Jersey 07083.

AHFS CATEGORY 8:12.28

S-0

editorial viewpoints

Medical Auxiliary Provides Unique Community Service

By Mrs. Lee Maxim, President
Woman's Auxiliary to MSMS

We hear so much about the "doctor's image" or the image of the doctor's wife. At this time in history we both receive an undue amount of criticism. When this was discussed at the last House of Delegates meeting of the Woman's Auxiliary to the American Medical Association, there were many solutions offered as to ways of improving these images. The first and most obvious suggestion was to hire a professional public relations firm to deal with the problem.

Now, I would never belittle the efforts of the public relations people, however, I feel the solution lies much closer at hand. It has been said that if you are alive you are involved with life. Whether we choose to become involved with the community or not, we are creating an image. It behooves us all to make it the type of image that will best serve the community, the medical profession and ourselves.

These next few months with the forthcoming elections, may well be the most critical time the medical profession has ever faced. We in the auxiliary are as vitally concerned about the future practice of medicine as all of you. We would like to assist you in any way we can, but we need your specific directions.

Our auxiliary is an untapped reservoir of many dedicated women who are not only willing but very able to help. Some contacts with the community are better made by women. Women, too, have more time to make these contacts. We are willing to help implement the American Medical Association's "Operation Grass Roots" program, but only if this is your wish.

One of the things that continue to plague our organization is the continual loss in total membership. Some women tell us that their husband insists that they belong to the hospital auxiliary. This is to be commended. There is a major difference between the hospital and the medical auxiliary. Hospital Auxiliaries are patient services-oriented, whereas medical auxiliaries are health services-oriented. We would hope you would encourage your wife to also belong to the medical auxiliary. We can provide a unique community service which is not duplicated by any other group.

Doctor, Encourage Your Assistant To Join the MSMAS

By (Mrs.) Patricia Austin, President
Michigan State Medical Assistants' Society

With the ever increasing complexity of medicine, finding competent office personnel is not a simple task. Today, a medical assistant must be nurse, psychologist, receptionist, bookkeeper, stenographer, medical and personal secretary, social worker, housekeeper and purchasing agent. Plus, she must have a smiling face, congenial disposition and a sympathetic manner.

Just as the evolution of medical care in this country has demanded vast changes in the training of physicians, so has educational training for the doctor's medical assistant become equally important. Today's professional medical assistant is an integral part of the health team.

Twenty years ago, under the auspices of the Michigan State Medical Society, the Michigan State Medical Assistants' Society was organized. The objectives of this society are to inspire its members to render honest, loyal and more efficient service to the profession and to the public which they serve; to strive at all times to co-operate with the medical profession in improving public relations; to render educational services for the self-improvement of its members and to stimulate a feeling of fellowship and co-operation among its members.

Paralleling the structure of the American Medical Association and the Michigan State Medical Society, the medical assistants' society has its own organizational procedures. Meetings are held monthly on the county level, featuring a topic relative to the field of medicine. The state organization meets twice a year for educational seminars, and holds an annual convention in April of every year. This, too, includes educational sessions.

Professional journals, expertly written and specifically oriented to the medical assistant, are mailed to every member.

The Maxine Williams Scholarship Fund, sponsored by the medical assistants' societies, and administered by the American Association of Medical Assistants, provides loans for aspiring medical assistants.

What can MSMAS do for the doctor's medical assistant? We offer her continuing education, inspiration from those involved in the same type of employment, personal development, self-confidence and leadership by contribution through this society and involvement in one's community through projects of the society.

Doctor, won't you encourage your medical assistant to join the Michigan State Medical Assistants' Society. All its activities have one objective — to make her career as a medical assistant happier and more successful. The dividends will be yours.

Membership information may be obtained by writing: Michigan State Medical Assistants' Society Membership Committee, 120 W. Saginaw, East Lansing 48823.

2,000 LIMITED PARTNERSHIP UNITS
IN MULTIVEST
REAL ESTATE FUND, LTD.
$2,500 Per Unit

The Partnership intends to invest its funds in real properties which the General Partner considers will offer a potential for profit either through the production of income or through gain on resale. Secondarily, when feasible within these objectives, the Partnership will also attempt to provide tax shelter for participants. At least 90% of investments will be in existing income producing real estate.

This announcement is neither an offer to sell nor a solicitation of an offer to buy these securities. This offer is made only by the prospectus in states where authorized, in compliance with state requirements. The Prospectus may be obtained from MultiVest Real Estate, Inc., or an authorized security dealer in any state where such offer may lawfully be made.

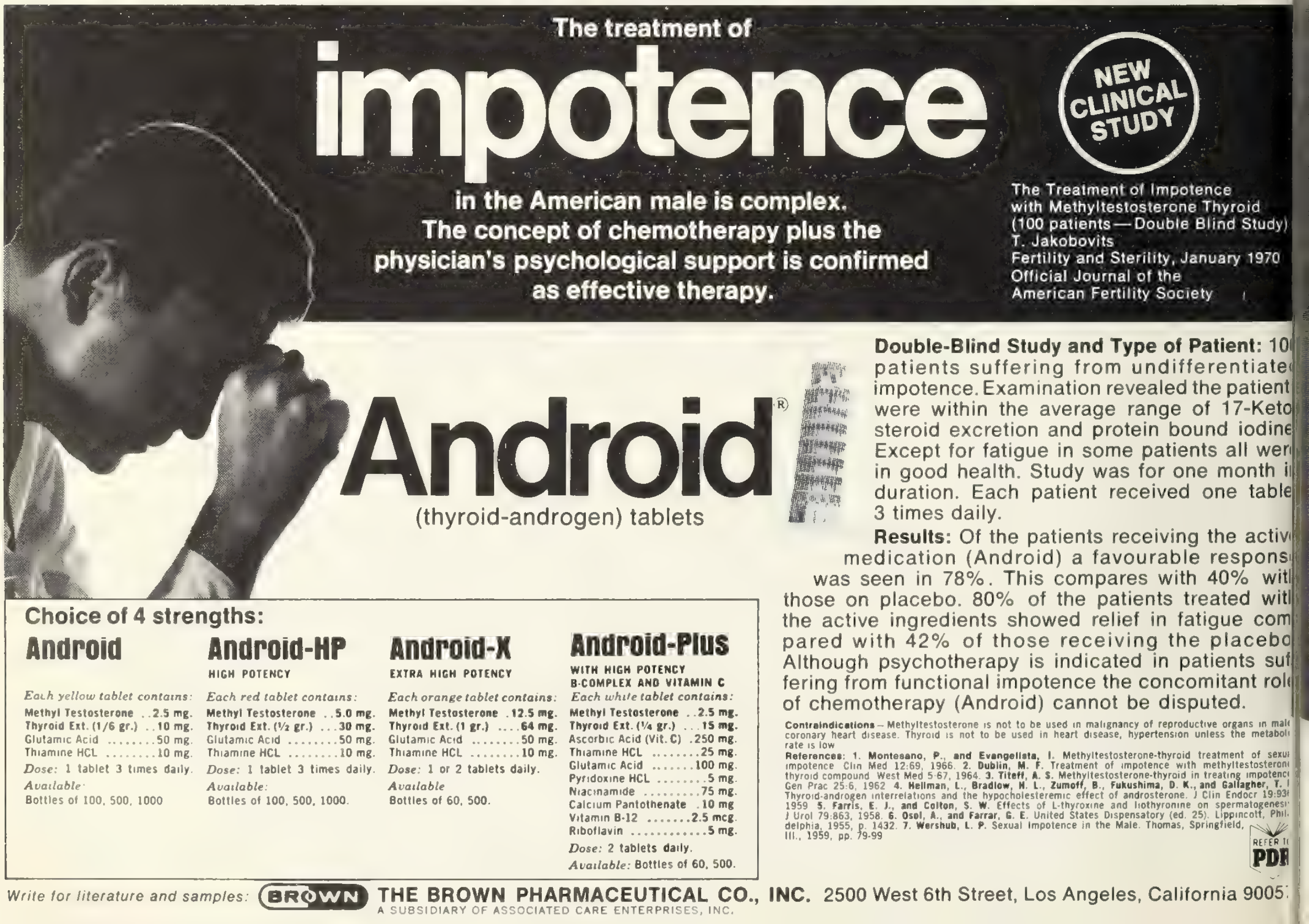
MultiVest Real Estate, Inc.

MAIL COUPON TODAY OR CALL (313) 352-3100

MultiVest Real Estate, Inc.
P.O. Box 550
Southfield, Michigan 48075

Gentlemen:
Please send me the free prospectus concerning MultiVest Real Estate Fund, Ltd.

NAME____________________
ADDRESS____________________
CITY__________ STATE________ ZIP_____



The treatment of
impotence
in the American male is complex.
The concept of chemotherapy plus the physician's psychological support is confirmed as effective therapy.

NEW CLINICAL STUDY

The Treatment of Impotence
with Methyltestosterone Thyroid
(100 patients—Double Blind Study)
T. Jakobovits
Fertility and Sterility, January 1970
Official Journal of the
American Fertility Society

Android®
(thyroid-androgen) tablets

Double-Blind Study and Type of Patient: 10 patients suffering from undifferentiate impotence. Examination revealed the patient were within the average range of 17-Keto steroid excretion and protein bound iodine Except for fatigue in some patients all wer in good health. Study was for one month i duration. Each patient received one table 3 times daily.

Results: Of the patients receiving the activ medication (Android) a favourable respons was seen in 78%. This compares with 40% wit those on placebo. 80% of the patients treated wit the active ingredients showed relief in fatigue com pared with 42% of those receiving the placebo Although psychotherapy is indicated in patients suf fering from functional impotence the concomitant rol of chemotherapy (Android) cannot be disputed.

Choice of 4 strengths:

Android	**Android-HP**	**Android-X**	**Android-Plus**
	HIGH POTENCY	EXTRA HIGH POTENCY	WITH HIGH POTENCY B-COMPLEX AND VITAMIN C
Each yellow tablet contains:	*Each red tablet contains:*	*Each orange tablet contains:*	*Each white tablet contains:*
Methyl Testosterone ..2.5 mg. Thyroid Ext. (1/6 gr.) ..10 mg. Glutamic Acid ....50 mg. Thiamine HCL ....10 mg.	Methyl Testosterone ..5.0 mg. Thyroid Ext. (½ gr.) ...30 mg. Glutamic Acid ....50 mg. Thiamine HCL ....10 mg.	Methyl Testosterone .12.5 mg. Thyroid Ext. (1 gr.) ....64 mg. Glutamic Acid ....50 mg. Thiamine HCL ....10 mg.	Methyl Testosterone ..2.5 mg. Thyroid Ext. (¼ gr.) ...15 mg. Ascorbic Acid (Vit. C) .250 mg. Thiamine HCL ....25 mg. Glutamic Acid ....100 mg. Pyridoxine HCL ....5 mg. Niacinamide ....75 mg. Calcium Pantothenate .10 mg Vitamin B-12 ....2.5 mcg. Riboflavin ....5 mg.
Dose: 1 tablet 3 times daily.	*Dose:* 1 tablet 3 times daily.	*Dose:* 1 or 2 tablets daily.	*Dose:* 2 tablets daily.
Available: Bottles of 100, 500, 1000	*Available:* Bottles of 100, 500, 1000.	*Available* Bottles of 60, 500.	*Available:* Bottles of 60, 500.

Contraindications — Methyltestosterone is not to be used in malignancy of reproductive organs in mal coronary heart disease. Thyroid is not to be used in heart disease, hypertension unless the metabol rate is low

References: 1. **Montesano, P., and Evangelista, I.** Methyltestosterone-thyroid treatment of sexu impotence Clin Med 12:69, 1966. 2. **Dublin, M. F.** Treatment of impotence with methyltestoster thyroid compound West Med 5:67, 1964. 3. **Titeff, A. S.** Methyltestosterone-thyroid in treating impoten Gen Prac 25:6, 1962 4. **Hellman, L., Bradlow, H. L., Zumoff, B., Fukushima, D. K., and Gallagher, T.** Thyroid-androgen interrelations and the hypocholesteremic effect of androsterone. J Clin Endocr 19:93 1959 5. **Farris, E. J., and Colton, S. W.** Effects of L-thyroxine and liothyronine on spermatogenes J Urol 79:863, 1958. 6. **Osol, A., and Farrar, G. E.** United States Dispensatory (ed. 25). Lippincott, Phil delphia, 1955, p. 1432. 7. **Wershub, L. P.** Sexual Impotence in the Male. Thomas, Springfield, Ill., 1959, pp. 79-99

REFER T PDR

Write for literature and samples: BROWN **THE BROWN PHARMACEUTICAL CO., INC.** 2500 West 6th Street, Los Angeles, California 9005
A SUBSIDIARY OF ASSOCIATED CARE ENTERPRISES, INC.

Test drive an almost perfect car.

At Porsche, they've been trying o build the perfect car for more han 21 years.

From the first, they knew it was mpossible. But they kept trying n spite of that. Or, maybe, beause of that.

And they've come close.

We challenge you to test drive Porsche 911 and then try to put it out of your mind.

It has everything a great car should have. Including a powerful air-cooled engine, overhead cam, 4-wheel disc brakes, independent suspension, rack and pinion steering, unitized body and synchromesh transmission.

But more important, everything works together with such incredible harmony that no one part overshadows another.

The car responds so instantly and so accurately that it almost seems a part of the driver.

But, of course, it's still not perfect.

You might say it's only human.

PORSCHE®

Wood Imports, Inc.
15415 Gratiot Ave., Detroit

Tom Sullivan Porsche Audi, Inc.
499 S. Hunter Blvd., Birmingham

Phil Gordon's, Inc.
2924 E. Grand River Ave., Lansing

Prestige Automobiles, Inc.
2955 S. Division Ave., Grand Rapids

in memoriam

Walter A. Briegel, M.D.
Birmingham

Walter A. Briegel, M.D., retired general practitioner and obstetrician, died June 3 at the age of 84. He was a resident of Birmingham.

A graduate of Detroit Homeopathic Medical School, Doctor Briegel was affiliated with Grace Hospital, Detroit. He retired in 1952 after 37 years of practice in Detroit. Before that he practiced five years in Tecumseh.

Harold T. Crews, M.D.
Birmingham

Harold T. Crews, M.D., Birmingham, former chief of staff at Detroit's Grace Hospital, Northwest Unit, died June 5 at the age of 78.

Doctor Crews, a surgeon, was graduated from Toronto University School of Medicine and practiced medicine in Detroit for 50 years.

Henry J. Flaherty, M.D.
Farmington

Henry J. Flaherty, M.D., a member of the staff of Mt. Carmel Mercy Hospital since it was founded in 1939, died May 26 at the age of 61.

Doctor Flaherty was a specialist in obstetrics and gynecology and was past president of the Mt. Carmel Mercy Hospital staff. He was graduated from Wayne State University School of Medicine. He was a member of the American College of Obstetricians and Gynecologists and the obstetrics-gynecology section of the International College of Surgeons.

Ledru O. Geib, M.D.
Grosse Pointe Park

Ledru O. Geib, M.D., Detroit physician for nearly 60 years, died May 25 at the age of 88.

Doctor Geib, a graduate of Wayne State University School of Medicine, was on the staffs of Evangelical Deaconess, Jennings Memorial and Cottage hospitals in Detroit.

He was a member of the Wayne State University Medical School Alumni Association and the American Academy of General Practice.

W. William MacGregor, M.D.
Birmingham

W. William MacGregor, M.D., Detroit surgeon and physician for 55 years, died June 8, at the age of 83.

Doctor MacGregor was graduated in 1915 from the Detroit College of Medicine and also received a degree in pharmacy from Ferris State College. Doctor MacGregor was a past president of the Wayne County Medical Society. He was a fellow of the American College of Surgeons.

Carl A. Moyer, M.D.
Baraga

Carl A. Moyer, M.D., Baraga, pioneer in burn therapy and development of silver nitrate treatments for burns, died May 29 at the age of 61.

Doctor Moyer had been director of the Moyer Clinic in Baraga since 1967 and was one of 10 recipients from throughout the country to be cited for distinguished achievement by *Modern Medicine* in 1968.

He served as director of medical research at Michigan Technological University from 1965 to 1967 and as head of surgery at Washington University in St. Louis, Mo., from 1951 to 1965. He was graduated from the University of Michigan Medical School.

Doctor Moyer received the Henry Russell Award of the U-M for distinguished achievement in scholarly research and the Marchman Award for the most outstanding contribution to medicine in Texas.

Doctor Robinson

Remus G. Robinson, M.D.
Detroit

Remus Grant Robinson, M.D., Detroit surgeon and civic leader, died June 7 at the age of 66.

Doctor Robinson, who had been the first Negro elected to the Detroit Board of Education, was named "Physician of the Year" in 1961 by the Detroit Medical Society and in 1965 received an MSMS Certificate of Commendation. In 1967 he received a special State Volunteer Leadership Award from then-Gov. George Romney.

Doctor Robinson was graduated from the University of Michigan Medical School and was surgeon-in-chief at Parkside Hospital, as well as an attending physician at Providence and Grace Hospitals in Detroit.

Doctor Robinson served as chairman of the Wayne State University Board of Governors in 1958-59 and was president of the AFL-CIO Council on Political Education.

In addition he was president of the board of directors of the Detroit Urban League in 1949-51 and was a member of the Greater Detroit Hospital Fund.

John A. Scott, M.D.
Jackson

John A. Scott, M.D., Jackson physician for 37 years, died May 21 at the age of 66.

Doctor Scott was a graduate of the Detroit College of Medicine and Dentistry and had been a draft board examiner for 20 years. He was a member of the Academy of General Practice and the Michigan Heart Association.

Roger S. Siddall, M.D.
Sumter, S.C.

Roger S. Siddall, M.D., Sumter, S.C., retired head of the Department of Obstetrics and Gynecology at Highland Park General Hospital, died May 15 at the age of 75.

Doctor Siddall was past president of the Michigan Society of Obstetrics and Gynecology, a member of the Central Association of Obstetrics and Gynecology, the American College of Obstetricians and Gynecologists and the Detroit Academy of Medicine.

He was emeritus professor of obstetrics and gynecology at Wayne State University's School of Medicine. He was graduated from Johns Hopkins School of Medicine.

Kenneth N. Wells, M.D.
Grand Haven

Kenneth N. Wells, M.D., Grand Haven physician for 37 years, died May 28 in Iowa City at the age of 62.

Doctor Wells was affiliated with North Ottawa Community Hospital in Grand Haven and was a graduate of the University of Michigan Medical School. He was a past president of the Ottawa County Medical Society and was a member of the American Academy of General Practitioners.

painless intramuscular therapy for calcium deficiencies:

Calphosan®

calcium glycerophosphate, calcium lactate

To bring effective calcium therapy to the patient, Calphosan may be administered intramuscularly . . . without pain, inflammatory reactions, induration or sloughing. Injections twice weekly for a series of 5 to 10 injections are recommended.

Average dose per injection: One or two 10 ml. injections of Calphosan each week for the first four or five weeks, and on a when-needed basis thereafter.

Calphosan is a specially processed solution of calcium glycerophosphate and calcium lactate, containing 1% of each, in a physiological solution of sodium chloride. Each 10 ml. contains 50 mg. of calcium glycerophosphate, 50 mg. calcium lactate, with 0.25% phenol as preservative. Available in 10 ml. ampules in boxes of 10s and 100s; 60 ml. multiple-dose vials. Also available as Calphosan with B-12. U. S. Patent No. 2657172.

Contraindication: Hypercalcemia; neoplastic diseases; and fully digitalized patients. Do not use intramuscularly in infants and young children. Before starting therapy, consult complete product literature.

Write for free copy of "Calcium: The Ubiquitous and Essential Element" and for samples.

THE CARLTON CORP

Tenafly, New Jersey 07670

Classified Advertising

$5.00 per insertion of 50 words or less, with an additional 10 cents per word in excess of 50.

INTERNIST needed for established multi-specialty group in Detroit. Excellent professional relationship. Reply: Box 14, 120 W. Saginaw Street, East Lansing, Michigan 48823.

PSYCHIATRISTS: Avoid pollution – enjoy fresh air, clean water, less people in summer-winter vacationland near Interlochen Arts Academy. Small town peace and quiet. Big City culture and salaries. Progressive psychiatric hospital, JCAH approved, 3 year psychiatric residency program. Salaries to $32,364 if you qualify, excellent fringes, housing available. Contact M. Duane Sommerness, M.D., Traverse City State Hospital, Traverse City, Michigan 49684.

FAMILY PRACTICE PHYSICIANS – Board of Trustees of St. Mary's Hospital in Marquette invites family practice physicians to practice in Michigan's upper peninsula. This community has two hospitals, excellent schools, churches and year-round sports activities. This hospital is a 126 bed modern, well equipped, JCAH accredited general hospital including psychiatric and rehabilitation units in which to practice professional skills. Interested physicians may contact: Archie S. Narotzky, M.D., Chief of Staff, St. Mary's Hospital, Marquette, Michigan 49855.

FOR LEASE: In new medical, dental building. Two suites available, or will combine for a total of 2200 sq. ft. Also, 2500 sq. ft. of lower level area available, ideal for dental or other type laboratory. Will design street level and lower level to your specifications. Located in the City of Grandville, Michigan. Easy access to shopping centers, expressways, and housing. Lease includes paved offstreet parking, all utilities, and all services. Reply to Prairie Street Realty Corp., 2700 – 28th Street, S.W., Grand Rapids, Michigan or phone (616) 538-9000.

WANTED: Physician to join private group limited to the practice of industrial medicine. Top remuneration, profit sharing, pension plan, insurance program, liberal vacation program. REGULAR HOURS. Address replies to: R. R. Silver, M.D., 60 W. Hancock, Detroit, Michigan 48201 or call R. R. Silver, M.D., or D. Jacknow, M.D., at (313) TE 1-3130 or (313) 756-5800.

RADIOLOGIST, full-time, for accredited hospital in Detroit. Excellent remuneration. Reply to Box 16, 120 West Saginaw Street, East Lansing, Michigan 48823.

WANTED: Internist to join two man partnership in Michigan's upper thumb area. Excellent recreation and educational facilities are available. Write to: K. B. Herrington, M.D. or Kenneth S. Kube, M.D., 669 South Van Dyke, Bad Axe, Michigan. May call collect: (517) 269-6453.

EXTREMELY BUSY two man group needs OB man, who is willing to do some general practice, or a GP who particularly wants to do OB. New modern 80 bed hospital with CCU unit. Small town in Northern Michigan, serving an area of about 12,000 people. Office space available, and financial arrangements entirely open to discussion. P.C. possible. Write Box 12, 120 West Saginaw Street, East Lansing, Michigan 48823, or phone (517) 846-6122.

PSYCHIATRIC RESIDENCIES: We offer nothing but excellent psychiatric training in a stimulating, well-organized program located in a culturally advantaged community. Approved psychiatric training. Traverse City State Hospital, Michigan Department of Mental Health. Three and five year programs. Salary, Three Year Program: $11,359; $11,922; $12,925. Five Year Program: $12,945; $14,950; $17,393; $23,198; $24,409. NIMH-GP stipends available. Located in Michigan's serene, scenic recreation area on Grand Traverse Bay. Contact Dr. Paul E. Kauffman, Director of Training, Traverse City State Hospital, Traverse City, Michigan 49684. An equal opportunity employer.

WANTED: General Practitioner to associate with G. P. Surgeon in well established practice. Town of 2500, service area of 25,000. New open staff hospital. Salary $25,000 with early partnership opportunity. Excellent recreational area, good schools, community college, all churches. Exceptional opportunity. Contact: H. A. Timreck, M.D., 230 E. Cedar Street, Gladwin, Michigan 48624. Phone: (517) Office 426-9225, Home: 426-9233.

GENERAL PRACTITIONERS: Have you had your fill of the "Rat Race"? Are you tired of filling out forms such as for Medicare, Medicaid, etc.? If so, come with us. We have a campus which is going to grow to 20,000 students. We will be in a new Health Service building in 1972. We offer a competitive salary, excellent fringe benefits, and the opportunity to improve yourself. Contact: Harold J. Reese, M.D., Director, Student Health Service, Central Michigan University, Mt. Pleasant, Michigan 48858. Phone (517) 774-3058.

LOCUM TENENS: Doctor wanted for relief coverage of general practitioner for one to six months. Opportunity to continue association is open. Salary $2,000 per month. Contact: H. A. Timreck, M.D., 230 E. Cedar Street, Gladwin, Michigan 48624. Phone: (517) Office 426-9225, Home 426-9233.

EASTERN ILLINOIS progressive community 42,000 population; Universities of Illinois, Indiana and Purdue nearby; good schools, including junior college adjacent to hospital; new, well equipped General Medical and Surgical Hospital, interested in all specialties as well as GP; away from busy metropolitan traffic; 120 miles south of Chicago, 85 miles west of Indianapolis Via I-74; beautiful 9 hole championship golf course on grounds; an equal opportunity employer; salary $19,000 through $29,752 per year based on training and experience. Licensure in one state required for appointment. Write or call Chief of Staff, VA Hospital, Danville, Illinois 61832, Telephone (217) 442-8000 Ext. 353.

LOT FOR SALE: 148 feet on Michigan Avenue near Waverly road, Lansing, Michigan. Zoned for Medical-Dental Clinic with unlimited parking. Price $55,000. Contact: Norman D. Katz, or Steven I. Victor, 400 American Savings Building, 24700 Northwestern Hwy., Southfield, Michigan 48075. (313) 354-3500.

Index to Advertisers

Arch Laboratories 693
Becton, Dickinson 697, 698
*Breon Laboratories 647
*Bristol Laboratories 650, 651, 653
Brown Pharmaceuticals 720
*Burroughs-Wellcome & Co. 682
Campbell Soup Co. 679
Carlton Corp. 723
Classified Ads 724
Dow Chemical Co. 701
Harcliffe Laboratories 713
Hynson, Westcott and Dunning, Inc. 643
Import Motors 721
Ingram, G. A. Company 711
*Lederle Laboratories 644
*Lilly, Eli and Co. 656
Mallard, Inc. 699, 700
*Mead Johnson Laboratories 690, 691
*Medical Protective Co. 703
Mercywood Hospital 725
MultiVest Real Estate, Inc. 720
National Drug Co. 683, 684, 715, 716
Plainwell Sanitarium 696
Poythress, Wm. P. 702
Roche Laboratories .... Cover IV
*Sandoz Pharmaceuticals 707, 708, 709, 710
*Schering Corp. 717, 718
*Searle, G. D., and Co. 680, 681
*Smith, Kline & French Laboratories 655
*Stratton, Ben P., Ins. .... Cover II
Walker Corp. and Co. 686, 687

*These organizations will be represented in the Exhibit Hall at the 1970 MSMS Annual Scientific Session in Detroit, Sept. 23-24.

Established 1924

MERCYWOOD HOSPITAL

4038 Jackson Road **Conducted by Sisters of Mercy** **Ann Arbor, Michigan**

Telephone — 313 663-8571

Mercywood Hospital is a private neuropsychiatric hospital licensed by the Michigan Department of Mental Health. Mercywood specializes in intensive, multi-disciplinary treatment for emotional and mental disorders.

Accredited by the Joint Commission on Accreditation of Hospitals and the National League of Nursing. A full Blue Cross participating hospital.

Certified for: Medicare and M.A.A. programs

PSYCHIATRIC STAFF

Lyle M. Allis, M.D.
Robert J. Bahra, M.D.
Dean P. Carron, M.D.
Francis M. Daignault, M.D.
Gordon C. Dieterich, M.D.
James R. Driver, M.D.
Stuart M. Gould, Jr., M.D.
Leonard E. Himler, M.D.*
Sydney Joseph, M.D.
Jacob J. Miller, M.D.
Rudolf Nobel, M.D.
Richard D. Watkins, M.D.
Stephen C. Mason, M.D.
Philip M. Margolis, M.D.
Hubert Miller, M.D.

* 1904 - 1967

noted and quoted

BY HERB AUER, EXECUTIVE EDITOR

The out-going president of the AMA, Gerald D. Dorman, M.D., New York, in his report to the recent AMA convention in Chicago, said in part:

"We must plan to make medical care available to anyone who needs it, no matter who he is or where he lives, the nature of his problem or when it arises. It may seem that such a goal is impossible, but I do not think the public will accept that answer. Part of the answer lies in finding ways to redistribute medical care geographically; by finding ways to bring patients to health centers; or ways to take medical and health centers, on wheels or on wings, to areas where there are patients; by the use of two-way closed-circuit television; by widespread use of helicopters, or special city transportation fleets."

* * *

Just a few assorted quotations from a rather long article in the *Ladies Home Journal* about "The High Cost of Being Sick":

"Important as the doctor's feelings may be, our lives are more important. It is we who get sick. It is we who need doctors, nurses, medicines, X-ray examinations, laboratory tests, hospital care. It is we who cannot afford to pay, under present conditions, what these things cost. It is we who must go into debt or go without. It is we who must see that this question is settled, and settled right!

"Most doctors are honest, hard-working, underpaid individuals. Some authorities put their average income as low as two thousand dollars a year. And it seems to be rather generally agreed that the so-called successful city doctors seldom make more than five or six thousand dollars a year — not very high figures for men who have spent 10-12 thousand dollars in acquiring their education."

This article appeared in October, 1930.

* * *

The National Society for Medical Research reports "that no valid finding on the effects of marijuana can be expected for another two to seven years." And Science Research Society adds that "there is no standard yardstick for evaluating marijuana in scientific studies. The basic weed from which marijuana is made can vary from plant to plant and from country to country." SRS has cautioned in a statement: "Until scientifically proven results are obtained, it appears as foolhardy to smoke marijuana as it would be to take any other unknown drug or chemical agent just for kicks."

* * *

The Michigan Education Association at its recent annual meeting took action "transforming educational rhetoric into dynamic and aggressive action programs," according to an article in the *Michigan Publisher.* The MEA delegates voted to almost double their dues to increase the MEA budget from 3.8 million to 7 million. The MEA is expanding its professional staff from 39 to 127, establishing a MEA Political Action Council, creating a Division for Minority Affairs, and took other action "to make Michigan teachers and education totally relevant to the needs of the people of Michigan."

* * *

"Michigan should be providing 35% to 50% more medical education than is being provided at the present time," according to the Michigan Health Council. The Council news continues: "Currently we have a total of 1,400 students in medical schools at the University of Michigan, Wayne State University and Michigan State University. This compares to 5,000 in New York, 3,000 in Pennsylvania, 2,400 in Illinois and over 2,200 in California. New York and California have a physician-population ratio of over 175 physicians per 100,000 while Pennsylvania and Illinois have ratios of over 130 physicians per 100,000 and Michigan ranks far below with only 115 physicians (M.D. and D.O.) per 100,000."

* * *

Beware of "buzz words."

That's the warning issued by Thomas H. Barton in a recent issue of the IBM magazine, *Think.*

"Buzz words" make a pleasant buzzing sound in our ears when we roll them off our tongues but communicate very little to the hearer about the subject under discussion, is the contention that he makes.

Mr. Barton reports that "the businessman is now being asked to give *grass roots support* from this *economy of abundance,* this *affluent society,* to employ the *hard-core, the unemployable,* lest the *rising expectations* of the *fringe elements* lead the *militants* to *direct action.*"

Buzz words may overwhelm a person into believing that you know what you are talking about — but the audience may suspect the truth.

michigan medicine

FEATURES IN THIS ISSUE

- Comparison of Two Treatment Methods for Heroin Addiction
- Better Delivery of Mental Health Care Services
- Roster of County Delegates to MSMS Annual Session

John Bruder, of Wayne State University, was one of 11 Michigan medical students spending the summer in community hospitals around the state. For more pictures and information on the students' "head start" on clinical experience, see page 782 and 783.

U. C. SAN FRANCISCO
MEDICAL CENTER LIBRARY
OCT 8 1970

Michigan State Medical Society
September 1970, Volume 69, Number 17

Don't Miss 1970 MSMS Scientific Sessions, Sept. 23-24, Detroit

Jury-Proof

OR THE CLOSEST THING TO IT!

HAVE YOU LOOKED INTO OUR NEW PERSONAL PRESTIGE POLICY? IF NOT, NOW IS THE TIME.

Here's a Policy designed for and sponsored by the

MICHIGAN STATE MEDICAL SOCIETY

its main features:

- PROVIDES EXCESS LIABILITY COVERAGE IN AMOUNTS OF $1,000,000 TO $5,000,000
- PROTECTS AGAINST GAPS IN YOUR PRESENT INSURANCE
- EXCESS MAJOR MEDICAL UP TO $25,000

for more information

CALL US COLLECT: (517) 484-2578 TO LEARN FIRST HAND HOW WE CAN PROVIDE YOU WITH THIS NEEDED COVERAGE AT A REASONABLE COST

bps **BEN P. STRATTON AGENCY, INC.**
ESTABLISHED IN 1937

19400 WEST TEN MILE ROAD
SOUTHFIELD, MICHIGAN 48075
357-5083

107 N. BUTLER BLVD.
LANSING, MICHIGAN 48903
(517) 484-2578

Breaking News: Deadline August 12
August 1970, Volume 69, Number 16
Michigan State Medical Society

michigan medicine

MEDICAL CENTER LIBRARY

Doctor Walt Cites Outstanding Features Of 1970 MSMS Scientific Sessions

An outstanding program of widely varied topics, provocative and educational, is in the final stages of preparation before presentation at the 1970 MSMS Scientific Sessions Sept. 23-24 at the Sheraton-Cadillac Hotel, Detroit.

Program chairman Alexander J. Walt, M.D., chairman of general surgery at WSU School of Medicine, has presided for the third consecutive year over the securing of experts from many states to instruct the thousands of persons who will attend the Scientific Sessions.

The scientific meetings are offered free, with no registration fees, to all Michigan physicians, interns, residents and students.

Among the outstanding offerings on the program, cited by Doctor Walt, are (according to their order of occurrence):

Clinical Aspects of Pollution, 8:30 a.m. Wednesday, Sept. 23, East and West Rooms;

Current Controversies In Recertification and Relicensure of Physicians . . . Desirable? Feasible? By Whom? 8:30 a.m. Wednesday, Sept. 23, Grand Ballroom;

Exercise and Heart Disease, 9 a.m. Wednesday, Sept. 23, Woodward Room;

Reactions to the Pill and Dermatological Reactions to the Pill, 9:30 a.m. Wednesday, Sept. 23, English Room;

Panel presentation on Controversies in the Management of Diabetes Mellitus, 10:15 a.m. Wednesday, Sept. 23, Ballroom Annex;

First MSMS Annual Discourse, The Nurture of the Social Doctor, 11 a.m. Wednesday, Sept. 23, Grand Ballroom;

Exercise and the Heart, 2 p.m. Wednesday, Sept. 23, Woodward Room;

Diverticular Disease of the Colon, 4 p.m. Wednesday, Ballroom Annex;

National Health Insurance, 4 p.m. Wednesday, Sept. 23, Boulevard Room;

Use of Computers in Image Analysis, Radiographic Diagnosis and Reporting, 8:30 p.m. Wednesday, Woodward Room;

The Surgery of Gastro-Duodenal Ulceration — 1970, 2 p.m. Thursday, Sept. 24, Grand Ballroom, and

Psychological Implications of the Hospitalization of Children, 4 p.m. Thursday, Washington Room.

At all times during the two-day meeting, physicians will have the choice of at least three meetings offered concurrently, with new developments and techniques in general practice and each of the specialty areas to be presented.

Among the outstanding speakers engaged to come to the Michigan meeting are:

Thaddeus S. Danowski, M.D., professor of medicine at the University of Pittsburgh and chief of medicine at Magee Womens Hospital, Pittsburgh, Pa.;

William Haber, Ph.D., Ann Arbor, professor of economics and advisor to the executive officers, University of Michigan, former dean of the U-M College of Literature, Science and the Arts;

J. Beach Hazard, M.D., Cleveland, senior consultant in pathology, Division of Laboratory Medicine, Cleveland Clinic Foundation, and clinical professor of pathology at Case Western Reserve School of Medicine;

Franz J. Ingelfinger, M.D., Boston, editor of *The New England Journal of Medicine;*

T. G. Parks, M.Ch., F.R.C.S., Belfast, North Ireland;

John C. Sinclair, M.D., New York City, assistant professor of pediatrics, Columbia Medical Center, and

Ian M. Thompson, M.D., Columbia, Mo., professor and chairman, Section of Urology, University of Missouri-Columbia School of Medicine.

Special!

In this issue, a fold-out Master Schedule for the 1970 MSMS Scientific Sessions

		Cecil W. J. Hart, Chicago, assista
	The Eye: No Longer a Ball	Frederick J. Heyner, M.D., South
	National Health Insurance	William Haber, Ph.D., Ann Arb
Evening	Use of Computers in Image Analysis Radiographic Diagnosis and Reporting	Speaker to be Announced
	Evolution of the Incubator	John C. Sinclair, M.D., New York
	Public Forum on Emphysema	

Thursday Sept. 24

	Subjects	Speakers
Morning	Ecology and Its Relation to Obstetrics and Gynecology	William E. Cooper, Ph.D., East La Speaker to be Named – *Population* T. N. Evans, M.D., Detroit – *Popu*
	What's New in the Practice Of . . .	A. Martin Lerner, M.D., Detroit – Speaker to be Named – *Antibiotic* William S. Haubrich, M.D., Detroi James E. Baker, M.D., Battle Cree Yoshikazu Morita, M.D., Royal Oa Howard J. Dworkin, M.D., Royal Irwin J. Schatz, M.D., Detroit – *C* Paul R. Dumke, M.D., Detroit – *A* Donald L. Rucknagel, M.D., Ph.D. George Mikhail, M.D., Detroit – *L* Adrian Kantrowitz, M.D., Detroit
Luncheons	Lunch with Experts and Section Luncheons	
Afternoon	Lesions of the Thyroid Gland	J. Beach Hazard, M.D., Cleveland,
	The Surgery of Gastro-Duodenal Ulceration – 1970	Stanley O. Hoerr, M.D., Cleveland *Discussants*: David B. Roos, M.D., Brock E. Brush, M.D
	Errors in the Early Diagnosis of Cancer	Joseph C. Cerny, M.D., Ann Arb
		John R. McDonald, M.D., Detroit Earl J. Rudner, M.D., Southfield –
	Emergency Treatment of the Comatose Patient Including Dangers in Over- and Under-treatment	Jere M. Bauer, M.D., Ann Arbor; Raymond B. Bauer, M.D., Detroit;
	Activation of Latent Viruses in the Nervous System The Pathogenesis of Slowly Progressive Degenerative Diseases	D. Carleton Gajdusek, M.D., Beth and Study of Child Growth and tutes of Neurological Diseases ar
	Surgery of the Esophagus	Eduardo Arciniegas, M.D., Detro R. F. Wilson, M.D.; A. Arbulu, Conrad R. Lam, M.D., Detroit –
	Ischaemic Colitis	T. G. Parks, M.Ch., F.R.C.S., Belf
	Diagnosis and Surgical Treatment of Thoracic Outlet Syndrome	David B. Roos, M.D., Denver, ass *Discussant*: J. C. Rosenberg, M.D.,
	Intravenous Agents – Trend or Detour	Ephraim S. Siker, M.D., Pittsburg
	Psychological Implications of the Hospitalization of Children	Henry P. Coppolillo, M.D., Ann A Paul V. Wooley, M.D., Detroit – *F* Frederico A. Arcari, M.D., Detroit
	Psychological Implications of Organ Transplanting	Stuart M. Finch, M.D., Ann Arbor Speaker to be Named – *Thoracic*
	Head and Cervical Spine Injuries in Football Cross-body Block, Major Cause of Knee Injuries	Richard C. Schneider, M.D., Ann Thomas R. Peterson, M.D., Ann A
	Current Concepts in Scoliosis	G. Dean MacEwen, M.D., Wilming
	A Three-Dimensional Look at Computers in Medicine	Richard C. Murray, New York Cit

At-a-Glance Master Timetable

1970 MSMS Scientific Sessi

Wednesday Sept. 23	Subjects	Speakers
Morning	Current Controversies in Recertification, Relicensure Of Physicians — Desirable? Feasible? By Whom?	Palmer H. Futcher, M.D., Phila
	Reasonable Expectations from Therapy of Diabetes	Thaddeus S. Danowski, M.D.,
	Controversies in Management of Diabetes Mellitus	Keats K. Vining, M.D., Grand Richard D. Hohl, M.D., Detroi
	Clinical Aspects of Pollution	Bertram D. Dinman, M.D., Ann Maurice H. Reizen, M.D., Lans Harold D. Newson, Ph.D., East
	Extended Bladder Flap Repair; Replacement of Ureter	Ian M. Thompson, M.D., Colum *Discussants*: James M. Price, Jr.
	Exercise and Heart Disease, *Michigan Heart Association*	
	Various ECG Exercise Testing Methods And Relation to Cardiac Work Evaluation	John G. Bielawski, M.D., Detroi
	Early Ambulation of the Coronary Patient	Jack M. Kaufman, M.D., Detroi
	Medical Versus Surgical Revascularization	Agustin Arbulu, M.D., Detroit;
	Use of the 10-Hour ECG	Seymour Wilhelm, M.D., Detroi
	Community Programs in Physical Fitness	Charles Eising, Detroit YMCA's Ernie Barnett, Detroit Dept. Pa Paul Flagg, Vice President Sidne Nat Coleman, Head Physical In
	Reactions to the Pill	J. M. Maas, M.D., Indianapolis,
	Dermatological Reactions to the Pill	Ralph J. Coskey, M.D., Oak Par
	Current Controversies In . . . Does the Annual Physical Serve a Useful Purpose?	*Con Side:* Michael J. Brennan,
	Annual Discourse — "Nurture of the Social Doctor"	Franz J. Ingelfinger, M.D., Bost
	The Tailored Abdominal Pedicle Flap In Reconstructive Surgery of the Hand	John C. Kelleher, M.D., Toledo director, Plastic and Reconstru
Luncheons	MDPAC — Woman's Auxiliary Luncheon Lunch with Experts and Section Luncheons	U. S. Congresswoman Martha G
Afternoon	Symposium on Exercise and the Heart, *American Medical Association, Michigan State Medical Society, Michigan Heart Association, President's Council on Physical Fitness and Sports*	
	Exercise and the Cardiovascular System	Samuel M. Fox, III, M.D., Bethe
	Prescribing Exercise Programs for the Well Patient	Allan J. Ryan, M.D., Madison,
	Conditioning Exercises in a Physical Fitness Program	William L. Haskell, Ph.D., Los
	Exercise Programs Following Cardiovascular Episodes	John Naughton, M.D., Washing
	Problems Incidental to Exercise Programs	Gerald A. O'Connor, M.D., Ann
	The Handling of Respiratory Distress Patients In a Non-University Hospital	Thomas A. Helmrath, M.D., Eas John C. Sinclair, M.D., New Y
	Management of Amputations within the Hand — The Immediate Care and the Extended Reconstruction	John C. Kelleher, M.D., Toledo
	Hypersensitivity Pneumonities — A Syndrome of Ever-Increasing Practical Importance	Jordan N. Fink, M.D., Milwauk Allergy Section, Wood Veterans
	Treatment of Cervical and Lumbar Injury with Traction	Samuel C. Colachis, M.D., Pho pital Medical Center, Veterans

Register Now For All-Day PG Courses

Hypertension
Wednesday, September 23

Course Director:

Robert M. Daugherty, Jr., M.D., Ph.D., Associate Professor of Medicine and Physiology, MSU College of Human Medicine; Director, Hypertension Clinic, Sparrow Hospital, Lansing.

Speakers:

Martin F. Jones, M.D., Director, Hemodialysis Unit, Sparrow Hospital, Lansing; Assistant Clinical Professor, Department of Medicine, MSU College of Human Medicine.

John R. Caldwell, M.D., Detroit, Hypertension Unit, Henry Ford Hospital, Detroit.

Harriet P. Dustan, M.D., Research Division, Hypertension Unit, Cleveland Clinic.

J. Richard Crout, M.D., Professor, Department of Pharmacology, MSU College of Human Medicine.

Stevo Julius, M.D., Hypertension Unit, University Hospital, University of Michigan.

William Eyler, M.D., Department of Radiology, Henry Ford Hospital, Detroit.

Roger Rian, M.D., Department of Radiology, Henry Ford Hospital, Detroit.

Clinical Pharmacology and Therapeutics
Wednesday, September 23

Course Director:

Edward A. Carr, Jr., M.D., professor of internal medicine and pharmacology; director of the Upjohn Center for Clinical Pharmacology, University of Michigan.

Speakers:

Edward A. Carr, Jr., M.D., professor, internal medicine and pharmacology; director of the Upjohn Center for Clinical Pharmacology, University of Michigan.

Lawrence G. Raisz, M.D., professor, pharmacology and medicine, University of Rochester, New York.

David R. Rovner, M.D., associate professor, internal medicine, University of Michigan Medical School.

Jose E. Yanez, M.D., assistant professor, medicine, Wayne State University School of Medicine.

Walter M. Baird, M.D., assistant clinical professor, pharmacology, MSU College of Human Medicine; member of the Greenlawn Medical Group.

John L. McNay, M.D., professor of medicine (clinical pharmacology), Emory University, Atlanta, Ga.

Charles N. Inniss, M.D., pediatrician, Organization and Direction of Emergency Medical Teams for Treatment of Poisonings and Adverse Reactions, Detroit.

MSMS One Day Postgraduate Courses
September 23 & 24, Howard Johnson Motor Lodge Downtown

Course Registration

Two courses to run simultaneously each day from 8 a.m. to 5 p.m. Registration is limited to the first 35 persons enrolling in each course. Course fee: $15 per course. Your check made out to the Michigan State Medical Society must accompany this advance registration.

Wednesday, September 23	(check one)	**Thursday, September 24**	(check one)
Hypertension	________	Allergy for the Non-Allergists	________
Clinical Pharmacology and Therapeutics	________	Shock, Blood, Fluids and Electrolytes	________

Name________________________________

Address________________________________

Check Enclosed________________________________

Clip and Mail with check to MSMS, Box 950, East Lansing 48823

Allergy for the Non-Allergists
Thursday, September 24

Course Director:

James A. McLean, M.D., Professor, Internal Medicine, University of Michigan Medical School.

Speakers:

James H. Wells, M.D., assistant professor, internal medicine, University of Michigan Hospital.

Neal A. Vanselow, M.D., associate professor, internal medicine; professor, Department of Postgraduate Medicine, University of Michigan Hospital.

Jordan N. Fink, M.D., associate professor, internal medicine, Marquette School of Medicine.

Sidney Friedlaender, M.D., assistant clinical professor, Wayne State University School of Medicine; chief, Allergy Section, Sinai Hospital, Detroit.

Larry Sweet, M.D., chief, Division of Allergy and Clinical Immunology, Henry Ford Hospital, Detroit.

Rudolph E. Wilhelm, M.D., chief, VA Allergy Service; Adjunct Associate Professor, Dermatology, Wayne State University School of Medicine.

Robert M. Cutler, M.D., director of medical education, St. Joseph Hospital, Pontiac.

Shock, Blood, Fluids and Electrolytes
Thursday, September 24

Course Director:

Robert F. Wilson, M.D., Associate Professor, Surgery, Wayne State University School of Medicine.

Speakers:

Rolf M. Gunnar, M.D., Riverdale, Illinois

William C. Shoemaker, M.D., New York City

Francis J. Haddy, M.D., professor and chairman, Department of Physiology, MSU College of Human Medicine

Herbert J. Robb, M.D., Birmingham

Eberhard F. Mammen, M.D., Detroit

Benjamin M. Lewis, M.D., Detroit

Yoshikazu Morita, M.D., chief, Department of Medicine, Wm. Beaumont Hospital, Royal Oak; adjunct associate professor, medicine, Wayne State University School of Medicine.

Richard S. McCaughey, M.D., Detroit

A. Martin Lerner, M.D., professor, medicine; chief, Infectious Diseases, Wayne State University School of Medicine.

Physicians visit exhibits at 1969 Annual Session.

Full Day of Programs Offered On Exercise and Heart at Annual Session

A full day of programs on the effect of exercise on heart disease and the heart will be a special feature of the 1970 MSMS Annual Session forthcoming in Detroit. The Annual Session is scheduled Sept. 20-24 at the Sheraton-Cadillac Hotel.

The Michigan Heart Association, in cooperation with MSMS and the AMA, will present a 9 a.m. to noon symposium on Exercise and Heart Disease at the Sheraton-Cadillac Wednesday, Sept. 23.

From 2 to 5 p.m. the same day, also in the Sheraton-Cadillac, the Committee on Exercise and Physical Fitness of the AMA, MSMS, the Michigan Heart Association and the President's Council on Physical Fitness and Sports will sponsor a seminar on Exercise and the Heart.

Both will be staged in the Woodward Room of the Sheraton-Cadillac.

Presiding over the morning program, for general practitioners, internists, cardiologists and physicians interested in the medicine of athletics, will be Harold E. DePree, M.D., director, cardiology services, Bronson Hospital, Kalamazoo, and president of the Michigan Heart Association.

Topics of the morning program will include Various ECG Exercise Testing Methods and Relation to Cardiac Work Evaluation, Early Ambulation of the Coronary Patient, Medical Versus Surgical Revascularization, Use of the 10-Hour ECG and Community Programs in Physical Fitness.

The afternoon program will be directed at physicians and key personnel in pathology, athletic medicine and physical education. Presiding will be Fred V. Hein, Ph.D., director, Department of Health Education, AMA.

Greetings will be brought by Robert J. Mason, M.D., Birmingham, MSMS president; Jack M. Kaufman, M.D., chairman of the Physician Education Committee of Detroit, and J. P. Wilbern, administrator of the President's Council on Physical Fitness and Sports.

Topics of the program on Exercise and the Heart will be Exercise and the Cardiovascular System, Prescribing Exercise Programs for the Well Patient, Conditioning Exercises in a Physical Fitness Program, Exercise Programs Following Cardiovascular Episodes and Problems Incidental to Exercise Programs.

Speakers, who include many authorities from other states, are listed in the fold-out program in the center of this issue.

Sept. 23-24, Wednesday-Thursday
Sheraton-Cadillac Hotel, Detroit

Final arrangements are being completed now and a program booklet will be mailed to all members about Sept. 5.

tive director, American Board of Internal Medicine

a., professor of medicine, University of Pittsburgh

Treatment; Janette B. Sherman, M.D., Southfield — *Diguanides*
eas; Jack A Litwin, M.D., Detroit — *Insulin*

: Ian T. T. Higgins, M.D., M.R.C.P., Ann Arbor — *Lungs*
akes; Speaker to be Named — *Dermatological Aspects*
sticides

rman, Urology, School of Medicine, University of Missouri
vey Y. Lewis, M.D., Detroit

l, M.D., Detroit; Jack M. Kaufman, M.D., Detroit

ealth and Physical Education
ation, Assistant Director of Recreation
vest Club, Detroit
y-Hill Northwest Club, Detroit

arch Division, the Lilly Research Laboratories, Eli Lilly Co.

Pro Side: Herman J. Alvarez, Jr., M.D., Detroit

he New England Journal of Medicine

ciate in plastic surgery, Medical College of Ohio at Toledo;
Service, St. Vincent Hospital and Medical Center

Lenore Romney

n, AMA Committee on Exercise and Physical Fitness

onsultant, President's Council

orge Washington University School of Medicine

bert Gregg, M.D., Detroit;
stant professor of pediatrics, Columbia Medical Center

professor of medicine, Marquette School of Medicine, chief of
on Hospital

director, physical medicine and rehabilitation, St. Luke's Hos-

Postgraduate Courses

Choice
Of Four All-Day
Postgraduate
Courses,
Howard Johnson
Motor Lodge Downtown

Enrollments are being accepted now for the four courses, $15 each. Limit of 35 physicians for each course. Write MSMS, Box 950, East Lansing 48823.

#1 Hypertension

Continuous
From 9 to 5

Course Director:
Robert M. Daugherty, Jr., M.D., Ph.D., Lansing
Moderator, Session I:
Martin F. Jones, M.D., East Lansing
Faculty:
John R. Caldwell, M.D., Detroit
Harriet P. Dustan, M.D., Cleveland
J. Richard Crout, M.D., East Lansing
Moderator, Session II:
Robert M. Daugherty, Jr., M.D., Ph.D., Lansing
Faculty:
Stevo Julius, M.D., Ann Arbor
William Eyler, M.D., Detroit
Roger Rian, M.D., Detroit
Harriet P. Dustan, M.D., Cleveland

#2 Clinical Pharmacology And Therapeutics

Continuous
From 9 to 5

Course Director:
Edward A. Carr, Jr., M.D., Ann Arbor
Faculty:
Lawrence G. Raisz, M.D., Rochester, N.Y.
David R. Rovner, M.D., Ann Arbor
Jose E. Yanez, M.D., Detroit
Walter M. Baird, M.D., Lansing
John L. McNay, M.D., Atlanta, Ga.
Charles N. Inniss, M.D., Detroit

of economics, advisor to the executive officers, U-M

ove)

onment

ls

ease

gy
r Medicine

– Human Genetics

upport and Replacement

aboratory Medicine, Cleveland Clinic Foundation

ard O. Kraft, M.D., Ann Arbor
exander J. Walt, M.D., Detroit

ation in the Diagnosis
tment of Testicular Neoplasms
est
in Lesions

ka, M.D., Detroit
genstein, M.D., Lansing

Laboratory of Slow Latent and Temperate Virus Infections
and Disease Patterns in Primitive Cultures, National Insti-

sophageal Fistulas of the H-Type
– 23 Cases of Spontaneous Perforation of the Esophagus
gement of Schatzki's Ring of the Esophagus

nd

professor of Surgery, University of Colorado Medical Center

r, Department of Anesthesiology, Mercy Hospital

Psychiatrist
Villiam A. Ellis, Jr., M.D., Ann Arbor – *Psychiatric & Resident*
rgeon; Lee F. Hurshman, M.D., Ann Arbor – *Pediatric Resident*

Dean A. LeSher, M.D., Detroit – *Internist-Renal Transplant*
mas Scullion, Ph.D., East Lansing – *Social Worker*

cal Director and Chief Surgeon, Alfred I. duPont Institute

munications and Systems Manager, AT and T

Postgraduate Courses

#3 Allergy For the Non-Allergists Continuous From 9 to 5

Course Director:
James A. McLean, M.D., Ann Arbor
Faculty:
James H. Wells, M.D., Ann Arbor
Neal A. Vanselow, M.D., Ann Arbor
Jordan N. Fink, M.D., Milwaukee
Sidney Friedlaender, M.D., Detroit
Larry Sweet, M.D., Detroit
Rudolph E. Wilhelm, M.D., Detroit
Robert M. Cutler, M.D., Pontiac

#4 Shock, Blood, Fluids And Electrolytes Continuous From 9 to 5

Course Director:
Robert F. Wilson, M.D., Detroit
Faculty:
Rolf M. Gunnar, M.D., Riverdale, Ill.
William C. Shoemaker, M.D., New York City
Francis J. Haddy, M.D., East Lansing
Herbert J. Robb, M.D., Birmingham
Eberhard F. Mammen, M.D., Detroit
Benjamin M. Lewis, M.D., Detroit
Yoshikazu Morita, M.D., Royal Oak
Richard S. McCaughey, M.D., Detroit
A. Martin Lerner, M.D., Detroit

"Physicians in training must be exposed to methods (and ideas) for keeping abreast of the scientific advances and social requirements of tomorrow. Anything less than this will leave them technologically and philosophically obsolete."
—James W. Haviland, M.D.,
Seattle, President-Elect
of American College of Physicians;
Member of AMA Council on Medical Education.

Governor Signs Basic Science Act Amendment

Gov. William G. Milliken has signed into law the public act amending the 32-year-old Basic Science Act.

This change has long been sought by the Michigan State Medical Society, the Michigan Health Council and many community groups as the quickest way to get more doctors into Michigan.

The bill, HB 4059, which was signed into law by Gov. Milliken on Aug. 2, requires that only physicians trained in foreign countries must take the basic science examination.

Michigan Society of Psychiatry and Neurology To Offer Monthly PG Course on Childhood and Adolescence

The psychological aspects of childhood and adolescence will be studied in a series of postgraduate courses in psychiatry being offered monthly September through May by the Michigan Society of Psychiatry and Neurology.

For physicians and other professionals, the courses will be held from 1 to 5 p.m. one afternoon each month, with classes scheduled simultaneously in Alma, Flint, Grand Rapids, Kalamazoo, Lansing, Saginaw, Howell and Jackson.

Physicians will serve as coordinators for the courses in each location. Further information may be obtained from Jose J. Llinas, M.D., 401 W. Greenlawn, Lansing, 48910, director and chairman of the Department of Post-graduate Training of the Michigan Society.

Mr. Brenneman Voices Appreciation for Assistance in State Senate Contest

Deep appreciation for financial support and assistance received during the recent primary election campaign is expressed by Hugh W. Brenneman, who resigned in June as the MSMS executive director to enter the contest for the State Senate.

Mr. Brenneman, who served MSMS in several positions of executive leadership for 24 years, ran a strong race to place third among six candidates. The contest for the Republican nomination to the Ingham County seat was close with Philip Pittenger, of Lansing, the apparent winner by 16 votes over Mrs. Polly Gibson. Mrs. Gibson has until August 23 to challenge the tabulation of votes. Mr. Pittenger currently is serving in the Michigan House of Representatives.

Many physicians and wives contributed to the Brenneman-for-Senate fund and many assisted in various ways in the campaign efforts.

Second Class Postage Paid at East Lansing, Mich. and at additional mailing offices.

michigan medicine

MICHIGAN STATE MEDICAL SOCIETY

Published semi-monthly, Trimonthly in December; 25 issues, by the Michigan State Medical Society as its official journal. Second class postage paid at East Lansing, Mich. and at additional mailing offices. Yearly subscription rate, $9.00. Printed in USA. All communications should be addressed to the Publications Committee, Michigan State Medical Society, 120 West Saginaw Street, East Lansing, Michigan 48823.

© 1970 Michigan State Medical Society.

Phone: Area Code 517, 337-1351.

UNIVERSITY OF CAL
LIBRARY SCH OF MED
THIRD & PARNASSUS AVE
SAN FRANCISCO CAL 94122

Breaking News
September 1970, Volume 69, Number 17
Michigan State Medical Society

michigan medicine

1970 MSMS House of Delegates To Convene Sept. 20-22 in Detroit

The 1970 MSMS House of Delegates will convene Sept. 20-22 at the Sheraton-Cadillac Hotel, Detroit, to elect new officers and to make important policy decisions affecting medical society activities during the coming year.

A highlight of the meeting will be the election of the MSMS president-elect, to take place Tuesday evening during the final session of the House of Delegates meeting.

In a departure from the 1969 order of business, the 1970 MSMS House of Delegates has scheduled all discussion of new resolutions to end before Tuesday evening, with the final session reserved exclusively for elections.

Four delegate and alternate delegate posts to the AMA will expire and be open for election. Current incumbents in these positions are Delegates Sidney Adler, M.D., Detroit; George W. Slagle, M.D., Battle Creek; Donald N. Sweeny, M.D., Detroit; Joseph A. Witter, M.D., Rochester, and Alternate Delegates James C. Danforth, Jr., M.D., Detroit; Marjorie Peebles-Meyers, M.D., Detroit; John J. Coury, M.D., Port Huron, and Vernon V. Bass, M.D., Saginaw.

Also expiring this year are terms of office for MSMS Councilors Ralph R. Cooper, M.D., Don W. McLean, M.D., and Robert K. Whiteley, M.D., Detroit (First District); Don Marshall, M.D., Kalamazoo (Fourth District); John R. Pedden, M.D., Grand Rapids (Fifth District), and Harold F. Falls, M.D., Ann Arbor (14th District).

Elections will also be held for the positions of speaker and vice speaker of the House.

Harold H. Hiscock, M.D., Flint, will be installed as new president of MSMS at an installation dinner Tuesday evening in the Book Casino of the Sheraton-Cadillac. All MSMS awards except the 50-year citations will also be presented at the dinner.

The official order of business for the 1970 MSMS House of Delegates meeting begins with 6 p.m. registration Sunday, Sept. 20 at the Grand Ballroom of the Sheraton-Cadillac, followed by the First Meeting at 8 p.m.

That evening's business will include a report of the Committee on Credentials, report of the Committee on Rules and Order of Business, remarks of the speaker, introduction of medical students, AMA-ERF presentation, address of the president, address of the president-elect, summary of the MSMS Judicial Commission, summary of the report of the delegates to the AMA, speaker's referral of House of Delegates committee reports, report of the Committee on Certificates of Commendation, introduction of resolutions, new business and recess for open forum.

The Second Meeting is scheduled at 8:30 a.m.

(Concluded on Back Page)

Great 1970 Annual Session Awaits Michigan Doctors

"We expect more Michigan doctors to attend the 1970 Annual Scientific Session in Detroit than last year," enthusiastically declares Robert J. Mason, M.D., MSMS President.

The Annual Session, Sept. 23-24, offers:
About 80 authoritative speakers;
Programs by each of the 24 MSMS Sections;
Timely programs by 23 specialty groups;
A new "Annual Discourse";
Four all-day Postgraduate Courses;
New "Lunch with the Experts" opportunities;
A special AMA Symposium on Exercise;
Series of talks on "What's New";
MDPAC-Auxiliary Congressional Luncheon;
Excellent Technical Exhibits, Etc.

"MSMS members should block out Sept. 23-24 now on their office appointment books and be in Detroit," Doctor Mason stresses.

MSMS Council in Midsummer Meeting Discusses MMS, Medicare Rate Freeze, Insurance Hearings

A special report to the Michigan Medical Service Executive Committee concerning a proposed revision of the MMS corporate structure was an important item discussed at the midsummer meeting of The MSMS Council.

Other important items at the meeting included action on two 1969 MSMS House of Delegates resolutions regarding freezing of Medicare rate of payment, and representation at professional liability insurance meetings.

At the MMS corporate meeting Sept. 22 in Detroit, the MMS may propose that its corporate body be composed of a certain number of physicians, DOs and consumers.

Robert H. Hamburg, M.D., MMS board chairman, told The Council at the midsummer meeting that doctors should have as big a voice as possible in the reorganized corporate body, but the time of the majority voice is gone.

Doctor Hamburg, in his account of the special report, reminded The Council of the so-called Kramer bill, which would change the Blue Shield board from physicians to consumers, with the entire board to be appointed by the governor. The bill has passed the House and is currently in a Senate committee.

Four possible alternatives of action, said Doctor Hamburg, include (1) letting the Kramer bill pass, (2) adopting the MMS board plan, (3) maintaining the status quo by attempting to defeat the Kramer bill and (4) dissolving the corporation.

In other action at the midsummer meeting, The Council referred discussion of the 1969 MSMS House Resolution 74 about Medicare freezing of rate of payment to the MSMS Finance Committee.

Legal Counsel's opinion indicated that extensive research would be required before any meaningful decision could be made with respect to the commencement of a case of such magnitude. Before MSMS decided to challenge the HEW ruling, Legal Counsel also advised The Council to re-examine the resolution from a public relations standpoint.

In further action, The Council authorized the chairman to delegate a representative of the medical profession to be included in hearings of the Michigan Insurance Commissioner about rate increases for professional liability companies. Legal Counsel had recommended that the action, proposed in 1969 MSMS House Resolution 71, might be worth trying for a year or two.

Doctor Yudashkin, New Mental Health Director, Challenged by Governor to Streamline Department

E. Gordon Yudashkin, M.D., newly-appointed director of the Michigan Department of Mental Health, has been asked by Gov. William Milliken for a "top-to-bottom" review which could streamline the department.

Doctor Yudashkin, who was formally named to the post on Aug. 13, succeeds William Anderson, M.D., who retired. Doctor Yudashkin had served as acting director since May 1.

Gov. Milliken, in a letter to Doctor Yudashkin, outlined what he expected of the new director, including implementation of a plan for regional mental health centers that Gov. Milliken said "should improve the department's responsiveness to citizen need."

Special 1970-71 Legislative Grants Allow for More Michigan Medical Students

A total of $195,000 in special "State Bureau of the Budget Augmentation Grants" is available for the first time this year to Michigan's three medical schools.

A certain amount was allocated by the legislature this summer to the medical schools, based on the total enrollment each school expects to have in the 1970-71 year.

The augmentation grants, according to Robert Endress of the Bureau of the Budget office, allow for an additional $13,000 for each freshman student that might be enrolled over the expected number. The purpose, according to Mr. Endress, is to encourage the schools to take even more students than they have planned.

Michigan State University's College of Human Medicine has already talked unofficially with the Bureau of the Budget office about obtaining funds for an additional four freshman students, but no other schools had contacted the office for more funds as this issue was being prepared.

Michigan's Medical Assistants Plan Leadership Seminar Sept. 26-27

The Michigan State Medical Assistants Society will hold a leadership training seminar Sept. 26-27 at the Campus Inn, Ann Arbor.

The seminar will include talks on Sept. 27 by Miss Alice Budny, past president, American Association of Medical Assistants, and by Joe Morris, M.D., professor of surgery at the University of Michigan Medical School, who will discuss cardiac surgery.

AMA President-elect, Chairman of the Board Address Chicago Communications Institute

"We are setting out to convince the American people that we are the ones — the only ones — who have the experience to lead" in the health care field, AMA President-elect Wesley W. Hall, M.D., told participants in the AMA's recent Communications Institute. He said the AMA will need communications, leadership and membership to make its programs possible.

More than 250 representatives of state and county societies attended the institute in Chicago, including Warren F. Tryloff, MSMS director, and Herbert A. Auer, manager, MSMS Communications Department.

CAPSULES

Members of the Woman's Auxiliary to the Michigan State Medical Society will meet with their husbands for a Congressional Luncheon being sponsored jointly Sept. 23 at the Pontchartrain Hotel, Detroit, by the auxiliary and the Michigan Doctors Political Action Committee (MDPAC). The Congressional Luncheon takes the place of a luncheon and fashion show previously planned by the auxiliary during its annual convention in conjunction with the 1970 MSMS Annual Session Sept. 20-24 in Detroit.

* * *

Donald N. Sweeny, Jr., M.D., Detroit, will address the AMA's Third National Congress on Medical Ethics Sept. 19-20 in Chicago. His topic will be the physician who practices in the "gray area" — that is, who is not a serious offender against ethical standards but is not a credit to the profession. Doctor Sweeny is chairman of the MSMS Judicial Commission and chairman of the MSMS delegation to the AMA.

Doctor Taylor

Doctor Bass

James B Blodgett M.D.

Doctor Blodgett

Important personages at the 1970 MSMS Annual Session Sept. 20-24 at the Sheraton-Cadillac Hotel, Detroit, will include Ross V. Taylor, M.D., Jackson, chairman of The MSMS Council, top left; James B. Blodgett, M.D., Royal Oak, speaker of the House, right, and Vernon V. Bass, M.D., Saginaw, vice speaker of the House, bottom left.

Mrs. Romney

Mrs. Griffiths

Congresswoman Martha W. Griffiths (D-Detroit) and Lenore Romney, candidate for the U.S. Senate, will speak at the luncheon Sept. 23 at the Hotel Pontchartrain, Detroit, being sponsored jointly by the Michigan Doctors Political Action Committee (MDPAC) and the Woman's Auxiliary to MSMS. The luncheon is scheduled at 12:15 p.m. during the first day of the 1970 MSMS Scientific Sessions. Co-chairmen are Louis R. Zako, M.D., Allen Park, MDPAC board member, and Mrs. Edward Maxim, St. Clair Shores, auxiliary president. Tickets are $5.50 and are limited in number. They may be reserved by writing MDPAC, Box 769, East Lansing 48823.

Monday morning, to include a supplementary report of the Committee on Credentials, summary of reports of The Council, summary of the report of Michigan Blue Shield, introduction of resolutions, presentation of 50-Year Awards and recess for open forum.

All reference committees will meet Monday afternoon at 1:30 p.m. and the entire House will reconvene at 7:30 p.m. Monday evening for the Third Meeting. It will include a supplemental report of the Committee on Credentials, unfinished business, reports of the reference committees followed by continuation of reference committee meetings and preparation of reports.

Reference committees will again meet Tuesday morning starting at 8 a.m. and the Fourth Meeting of the House is scheduled from 10 to 10:30 a.m. Wednesday morning, when business will include a supplemental report of the Committee on Credentials, reports and/or supplemental reports of reference committees.

The Michigan Medical Service corporate meeting is scheduled from 10:30 a.m. to 1 p.m. Tuesday, with the Fifth House of Delegates Meeting to follow at 2 p.m. Delegates at the Fifth Meeting will take up supplemental reports of the Committee on Credentials, unfinished business, and reports and/or supplemental reports of reference committees.

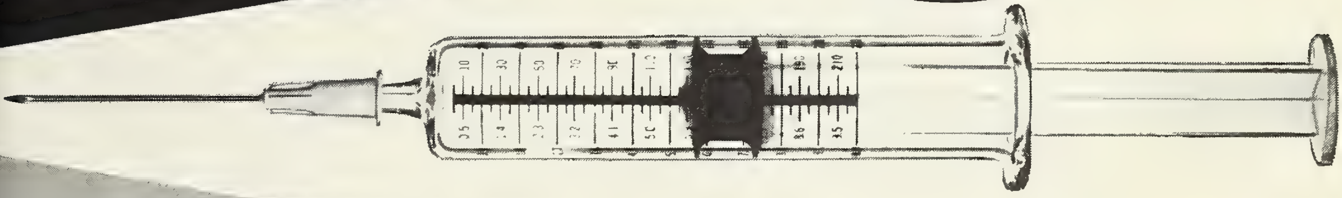
Preceding the installation dinner Tuesday evening MSMS delegates are invited to a "dutch treat" speaker's reception in the Caprice Lounge.

Incoming MSMS President Harold H. Hiscock, M.D., Flint, left, will succeed Robert J. Mason, M.D., Birmingham, right, 1969-70 MSMS president, in dinner ceremonies Tuesday evening, Sept. 22, during the 1970 MSMS Annual Session at the Sheraton-Cadillac Hotel, Detroit.

MICHIGAN MEDICINE is published Semi-Monthly, Trimonthly in December; 25 issues, by the Michigan State Medical Society, 120 W. Saginaw, East Lansing, Mich. 48823. Second class postage paid at East Lansing, Mich. and at additional mailing offices.

BSP® DISPOSABLE UNIT
HW&D BRAND OF SODIUM SULFOBROMOPHTHALEIN INJECTION, USP
(50 mg. per ml.)

BSP®



BROMSULPHALEIN® IN A STERILE, DISPOSABLE, ECONOMICAL UNIT

The Bromsulphalein test is a convenient, sensitive, reliable test of liver function.

The precalibrated syringe contained in the BSP Disposable Unit makes weight calculations unnecessary, providing proper dosage regardless of patient-weight. Each unit contains complete directions for use, precautions and contraindications.

The all-inclusive BSP Disposable Unit provides economic unit dispensing.

Complete literature available on request.

HYNSON,
WESTCOTT &
DUNNING, INC.

HW&D Baltimore, Maryland 21201

(BSPO4)

Corticosteroid therapy week after week.

then antibiotic therapy last week.

and monilial overgrowth this week.

For many patients on long-term corticosteroid therapy, the addition of oral antibiotic therapy may trigger monilial overgrowth in the intestine. When you anticipate such a problem, take action with DECLOSTATIN 300. It combines the broad-spectrum potency of demethylchlortetracycline with the antifungal effectiveness of nystatin—it helps avoid monilial take-over. Experience has shown DECLOSTATIN to be highly useful for many women patients; individual culture studies will show exactly where this usefulness may best be applied.

it doesn't let monilia begin where bacteria end.

Declostatin® 300

Demethylchlortetracycline HCl 300 mg and Nystatin 500,000 units Capsule-Shaped Tablets Lederle

Effectiveness. Because its antibacterial component is DECLOMYCIN® Demethylchlortetracycline, DECLOSTATIN should be equally or more effective therapeutically than other tetracyclines in infections caused by tetracycline-sensitive organisms. The antifungal component, nystatin, protects against superinfection by antibiotic-resistant fungal overgrowth (particularly monilia) in the intestinal tract.

Contraindication: History of hypersensitivity to demethylchlortetracycline or nystatin.

Warning: In renal impairment, usual doses may lead to excessive accumulation and liver toxicity. Under such conditions, lower than usual doses are indicated and, if therapy is prolonged, serum level determinations may be advisable. A photodynamic reaction to natural or artificial sunlight has been observed. Small amounts of drug and short exposure may produce an exaggerated sunburn reaction which may range from erythema to severe skin manifestations. In a smaller proportion, photoallergic reactions have been reported. Patients should avoid direct exposure to sunlight and discontinue drug at the first evidence of skin discomfort. Necessary subsequent courses of treatment with tetracyclines should be carefully observed.

Precautions: Overgrowth of nonsusceptible organisms may occur. Constant observation is essential. If new infections appear, appropriate measures should be taken. In infants, increased intracranial pressure with bulging fontanels has been observed. All signs and symptoms have disappeared rapidly upon cessation of treatment.

Side Effects: Gastrointestinal system—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. Skin—maculopapular and erythematous rashes; a rare case of exfoliative dermatitis has been reported. Photosensitivity; onycholysis and discoloration of the nails (rare). Kidney—rise in BUN, apparently dose-related. Transient, reversible, nephrogenic diabetes insipidus with excessive thirst and polyuria (rare). Hypersensitivity reactions—urticaria, angioneurotic edema, anaphylaxis. Teeth—dental staining (yellow-brown) in children of mothers given this drug during the latter half of pregnancy, and in children given the drug during the neonatal period, infancy and early childhood. Enamel hypoplasia has been seen in a few children. If adverse reaction or idiosyncrasy occurs, discontinue medication and institute appropriate therapy. Demethylchlortetracycline may form a stable calcium complex in any bone-forming tissue with no serious harmful effects reported thus far in humans.

Average Adult Daily Dosage: One tablet b.i.d. Should be given 1 hour before or 2 hours after meals, since absorption is impaired by the concomitant administration of high calcium content drugs, foods and some dairy products. Treatment of streptococcal infections should continue for 10 days, even though symptoms have subsided.

Lederle LEDERLE LABORATORIES, A Division of American Cyanamid Company, Pearl River, New York 448-9

michigan medicine

SCIENTIFIC EDITOR
John W. Moses, MD

EXECUTIVE EDITOR
Herbert A. Auer

MANAGING EDITOR
Judith Marr

ASSOCIATE SCIENTIFIC EDITORS
Jason Bodzin, MD
Detroit, House Staff
Frederick J. Cady, Jr., MD
Saginaw, Surgery
Robert M. Daugherty, MD
East Lansing, Basic Science
Harold E. DePree, MD
Kalamazoo, Medicine
Dean C. Elliott, MD
Petoskey, Otolaryngology
Tommy N. Evans, MD
Detroit, Obst.-Gyn.
E. Richard Harrell, MD
Ann Arbor, Dermatology
Dorin L. Hinerman, MD
Ann Arbor, Pathology
Samuel D. Jacobson, MD
Detroit, Medicine
Benjamin Jeffries, MD
Detroit, Psychiatry
Raymond S. Kurtzman, MD
Detroit, Radiology
A. Martin Lerner, MD
Detroit, Medicine
Charles E. Parkinson, MD
Battle Creek, Radiology
John C. Peirce, MD
Grand Rapids, Medicine
Frank H. Power, MD
Traverse City, Surgery
J. G. Turcotte, MD
Ann Arbor, Surgery
Alexander J. Walt, MD
Detroit, Surgery
Park W. Willis, III, MD
Ann Arbor, Medicine
Richard E. Wunsch, MD
Traverse City, Medicine

PUBLICATION COMMITTEE
Brooker L. Masters, MD
Chairman
Robert M. Leitch, MD
William A. LeMire, MD
Don Marshall, MD
Don W. McLean, MD
Milton R. Weed, MD

MICHIGAN MEDICINE is the official organ of the Michigan State Medical Society, published under the direction of the Publication Committee. Published Semi-Monthly, Trimonthly in December; 25 issues, by the Michigan State Medical Society as its official journal. Second class postage paid at East Lansing, Mich. and at additional mailing offices. Yearly subscription rate, $9.00; single copies, 80 cents. Additional postage: Canada, $1.00 per year; Pan-American Union, $2.50 per year; Foreign, $2.50 per year. Printed in USA. All communications relative to manuscripts, advertising, news, exchanges, etc., should be addressed to Publication Committee, Michigan State Medical Society, 120 West Saginaw Street, East Lansing, Michigan 48823. Phone Area Code 517, 337-1351. © 1970 Michigan State Medical Society.

* * *

MICHIGAN MEDICINE welcomes original scientific manuscripts, news items, photographs, features and letters presenting comments on issues. Authors may write to the MSMS Headquarters to obtain detailed instructions for the preparation of scientific papers.

SCIENTIFIC ARTICLES

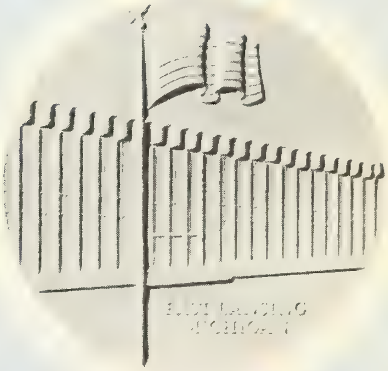
751 Heroin Addiction: A Comparison of Two Inpatient Treatment Methods; Maurice L. LaRouche, M.D.; Patrick T. Donlon, M.D.
755 Early Postoperative Discharge of Patients from the Hospital; Paul T. Lahti, M.D.
761 Air Embolism Following Open Heart Surgery: A Preventable Cause of Death; Walter H. Janke, M.D.; Ali A. Esfahani, M.D.
763 Unusual Clinical Course in Patients with Malignant Melanoma; William J. Foley, M.D.; William W. Coon, M.D.
767 A Controlled Study of Niacinamide Therapy in Rheumatoid Arthritis; George R. Thompson, M.D.; Ivan F. Duff, M.D.; Eigill F. Hvidberg, M.D.; Jack C. Barthwell, R.Ph.
771 New Drug Information; Fred J. Salter, Pharm. D.; Robert E. Pearson, M.S.

SPECIAL ARTICLES

782 How 11 Michigan Medical Students Spent Summer
798 The American Proctologic Society; James A. Ferguson, M.D.
800 The Industrial Medical Association; Duane L. Block, M.D.
809 80 Michigan Physicians Aiding Fayette, Miss.; Judith Marr
812 Toward Improved Health Care: A Consumer's View; Emil Mazey
834 Delegates and Alternates for 1970 MSMS Annual Session
846 1970 MSMS Annual Session Exhibitors

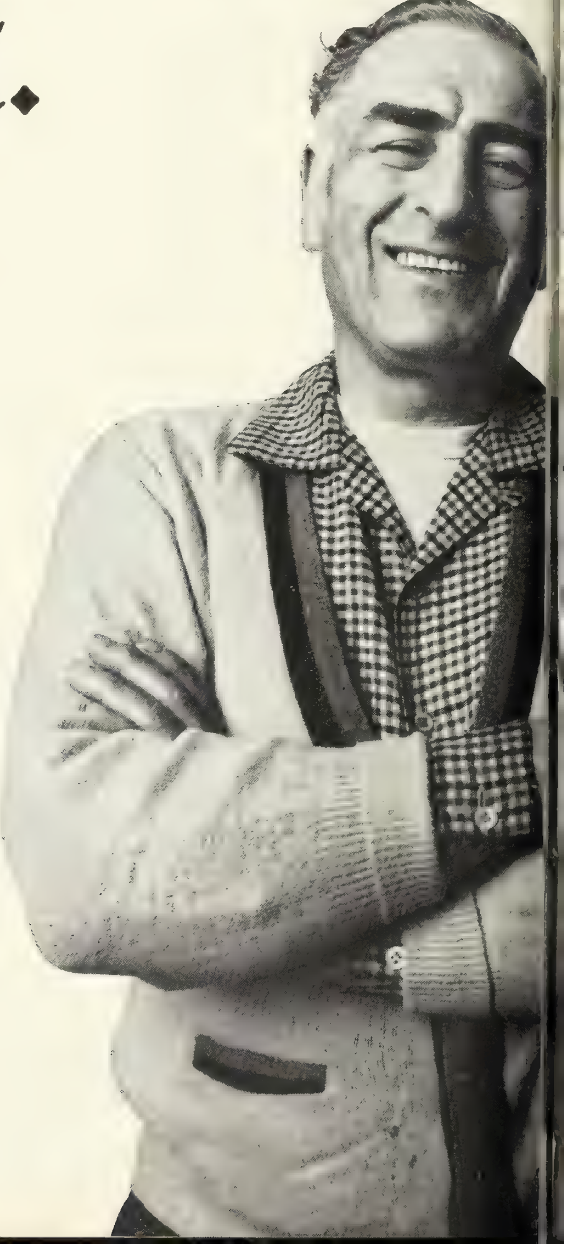
OTHER FEATURES

735 breaking news
744 msms leadership
745 officers' page
746 your opinion please
770 the viewbox
michigan authors
779 msms news
780 michigan mediscene
784 about doctors
791 medical care programs
792 mailbag
794 new members
798 special articles
802 county societies
812 ancillary
829 medico-legal
847 in memoriam
850 noted and quoted



MICHIGAN STATE MEDICAL SOCIETY
120 West Saginaw (P.O. Box 152)
East Lansing, Mich. 48823
Area Code 517, 337-1351

Menrium® treats the menopausal symptoms that bother him most.

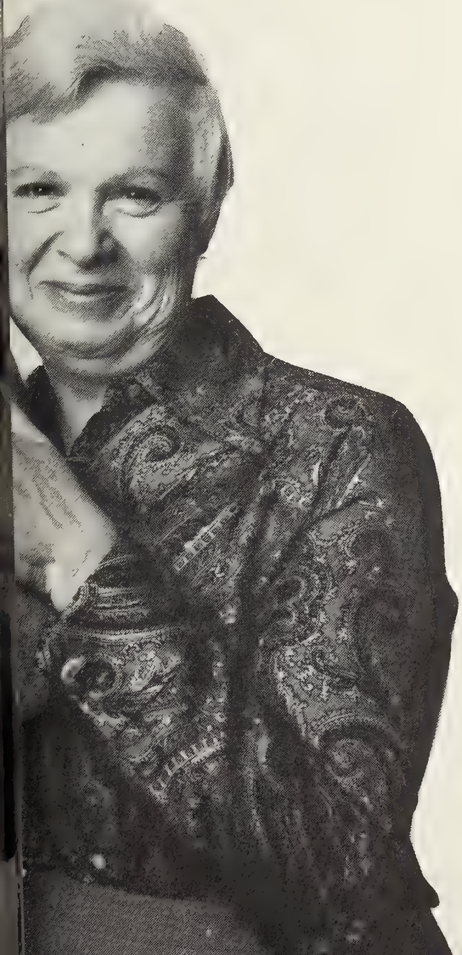


Roche
LABORATORIES
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

His wife has a lot of different nenopausal symptoms, but only a few eally irritate *him*. Her hot flashes, her ertigo, her palpitations—that's *her* roblem. What really bothers him is ıer nervousness, her irritability and ıer excessive anxiety, often expressed y endless "book-shuffling, chain-moking, reading-lamp" insomnia!

Menrium takes care of hot flashes, ertigo, palpitations in most nenopausal women. Menrium rovides the well-known antianxiety ction of chlordiazepoxide (Librium®) nd water-soluble esterified estrogens. t therefore relieves more symptoms han either component separately. t takes care of the vasomotor ymptoms as well as the emotional ymptoms. This means the symptoms hat bother his wife most. And the ymptoms that irritate him most.

So, to help them both get through *er* menopause, remember Menrium.



Before prescribing, please consult complete product information, a summary of which follows:

Indications: Management of manifestations generally associated with the menopausal syndrome—anxiety and tension, vasomotor complaints and hormonal deficiency states.

Contraindications: Women with cancer of breast or genitalia, except inoperable cases, and those with known hypersensitivity to chlordiazepoxide and/or esterified estrogens.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Exclude other possible causes of menopausal syndrome manifestations, such as pregnancy. Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions) similar to those seen with barbiturates have been reported following discontinuance of chlordiazepoxide HCl. Potential benefits of use in pregnancy, lactation or women of childbearing age should be weighed against possible hazards to mother and child. Clinical data inadequate on safety in pregnancy.

Precautions: In elderly and debilitated patients, limit dosage to smallest effective amount of chlordiazepoxide (initially 10 mg or less per day) to preclude ataxia or oversedation; increase gradually as needed and tolerated. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects—particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in patients with impaired renal or hepatic function. Paradoxical reactions to chlordiazepoxide (*e.g.*, excitement, stimulation and acute rage) have been reported in psychiatric patients. Employ usual precautions in the treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation very rarely reported in patients receiving Librium® (chlordiazepoxide) and oral anticoagulants.

Adverse Reactions: Untoward effects seen with either compound alone may occur with Menrium. With chlordiazepoxide, drowsiness, ataxia and confusion reported in some patients, particularly in the elderly and debilitated; while usually avoided by proper dosage adjustment, these are occasionally observed at lower dosage ranges. Also reported have been a few instances of syncope; isolated occurrences of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido, and occasional reports of blood dyscrasias, including agranulocytosis, jaundice and hepatic dysfunction. Periodic blood counts and liver function tests advisable during protracted treatment. Changes in EEG patterns (low-voltage fast activity) observed during and after chlordiazepoxide treatment.

With estrogens, headache, nausea and vomiting, anorexia, gastrointestinal discomfort, dysuria and urinary frequency, jitteriness, breast engorgement, formation of breast cysts, skin rashes and pruritus occasionally seen. Administration may also be associated with uterine bleeding and/or followed by withdrawal bleeding.

Usual Dosage: One tablet t.i.d. for 21 days, followed by one-week rest periods.

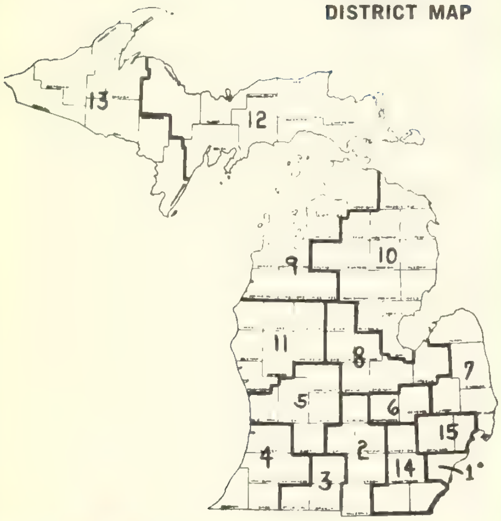
Menrium® T.I.D.

5 mg chlordiazepoxide		**0.2 mg water-soluble esterified estrogens**
5 mg chlordiazepoxide		**0.4 mg water-soluble esterified estrogens**
10 mg chlordiazepoxide		**0.4 mg water-soluble esterified estrogens**

msms leadership

PRESIDENT	Robert J. Mason, M.D.	Birmingham
PRESIDENT-ELECT	Harold H. Hiscock, M.D.	Flint
SECRETARY	Kenneth H. Johnson, M.D.	Lansing
ASST. SECRETARY	Brooker L. Masters, M.D.	Fremont
TREASURER	John R. Ylvisaker, M.D.	Pontiac
ASST. TREASURER	C. Allen Payne, M.D.	Gd. Rapids
SPEAKER	James B. Blodgett, M.D.	Detroit
VICE-SPEAKER	Vernon V. Bass, M.D.	Saginaw
PAST PRESIDENT	James J. Lightbody, M.D.	Detroit
COUNCIL CHR.	Ross V. Taylor, M.D.	Jackson
VICE-CHAIRMAN	Ralph R. Cooper, M.D.	Detroit

COUNCILOR DISTRICT MAP



First District Councilors: (Wayne County)
- Sidney Adler, MD, Detroit
- Ralph R. Cooper, MD, Detroit
- Don W. McLean, MD, Detroit
- Milton R. Weed, MD, Grosse Pointe Park
- Robert K. Whiteley, MD, Detroit

Second District Councilor: Ross V. Taylor, MD, Jackson
  Counties: Clinton, Eaton, Hillsdale, Ingham, Jackson
Third District Councilor: Robert M. Leitch, MD, Union City
  Counties: Branch, Calhoun, St. Joseph
Fourth District Councilor: Don Marshall, MD, Kalamazoo
  Counties: Allegan, Berrien, Cass, Kalamazoo, Van Buren
Fifth District Councilor: John R. Pedden, MD, Grand Rapids
  Counties: Barry, Ionia-Montcalm, Kent, Ottawa
Sixth District Councilor: Ernest P. Griffin, Jr., MD, Flint
  Counties: Genesee, Shiawassee
Seventh District Councilor: John J. Coury, MD, Port Huron
  Counties: Huron, Sanilac, Lapeer, St. Clair
Eighth District Councilor: A. Carl Stander, MD, Saginaw
  Counties: Gratiot-Isabella-Clare, Midland, Saginaw, Tuscola
Ninth District Councilor: Adam C. McClay, MD, Traverse City
  Counties: Grand Traverse-Leelanau-Benzie, Manistee, Northern Michigan (Antrim, Charlevoix, Cheboygan and Emmet combined), Wexford-Missaukee
Tenth District Councilor: Robert C. Prophater, MD, Bay City
  Counties: Alpena-Alcona-Presque Isle, Bay-Arenac-Iosco, North Central Counties (Otsego, Montmorency, Crawford, Oscoda, Roscommon, Ogemaw, Gladwin and Kalkaska, combined)
Eleventh District Councilor: Brooker L. Masters, MD, Fremont
  Counties: Mason, Mecosta-Osceola-Lake, Muskegon, Newaygo, Oceana
Twelfth District Councilor: William A. LeMire, Sr., MD, Escanaba
  Counties: Chippewa-Mackinac, Delta-Schoolcraft, Luce, Marquette-Alger
Thirteenth District Councilor: J. Robert Franck, Jr., MD, Wakefield
  Counties: Dickinson-Iron, Gogebic, Houghton-Baraga-Keweenaw, Menominee, Ontonagon
Fourteenth District Councilor: Harold F. Falls, MD, Ann Arbor
  Counties: Lenawee, Livingston, Monroe, Washtenaw
Fifteenth District Councilor: Sydney Scher, MD, Mount Clemens
  Counties: Macomb, Oakland

DIRECTOR	
Warren F. Tryloff	East Lansing
GENERAL COUNSEL	
Lester P. Dodd	Detroit
LEGAL COUNSEL	
A. Stewart Kerr	Detroit
ECON. CONSULTANT	
Clyde T. Hardwick	Detroit
HISTORIAN	
Wm. J. Stapleton, Jr., MD	Detroit
ASS'T HISTORIAN	
Wm. M. LeFevre, MD	Muskegon
SCIENTIFIC EDITOR	
John W. Moses, MD	Detroit

Doctor, Can You Say No?

The physician is in control of his patient's utilization of the medical care and services his patients require — or think they require.

But abuses in the utilization of care and services paid for by third-party have increased the premiums for underwritten insurance as well as the costs of medical care programs supported by the taxpayers.

Valid influences such as spiraling wages and prices are part of this great increase, but utilization has been an important contributor to the present high cost of medical care and services.

The Factors that have contributed include:

(1) Prescription drugs;
(2) Unnecessary admissions and lengths of stay in hospitals and nursing homes;
(3) Unnecessary laboratory tests and procedures;
(4) Unnecessary requests by the patient, for physicians' services in the home and office;
(5) Hospital outpatient department admissions for purely diagnostic purposes when such service is academic;
(6) Clinic visits for the same purposes as in No. 5 above;
(7) Admissions to skilled nursing care facilities when not required, and
(8) Acceding to patient pressures.

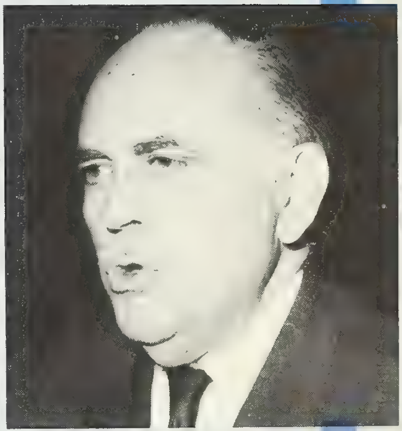
It is recognized that in many instances it is the demands of the patient or his family that are responsible for over-utilization.

And maximums have an insidious habit of becoming minimums. For example, Medicaid policy permits a maximum of 30 days' supply of medication as dispensed upon a prescription of a licensed physician, with three allowable refills. This assures that the patient has at least 120 days' supply of medications before he sees the doctor again.

Some physicians over-prescribe by providing too much medication at one time. Other physicians under-prescribe by providing too little medication at one time. The latter may force a situation that the physician requires the patient to come into the office every week, thus creating multiple fees for services.

In any system that provides a third party which pays the cost of care whether it is insurance or government, there must be an accountability factor. This is particularly so when public funds are used to pay for this care. We must all act as stewards of the public trust and work toward the assured delivery of needed high-quality medical care and services to those who need it and cannot afford to pay its costs — at the lowest possible cost to tax payers.

The physician actually receives only about 13% of the dollars spent for medical care, but, he is responsible for about 70% of those costs because of the services he orders for his patients.



Robt. J. Mason, M.D.
MSMS President

your opinion please

In view of the increasing complexity and confusion that exists in the delivery of mental health care services, what suggestions would you make to best insure fullest delivery of services to all persons requiring mental health care?

Stuart L. Cohn, M.D.
Alpena

Doctors must come to realize that good mental health care services are a result of teamwork. The team includes community facilities and services, physicians, psychiatrists, general hospitals, psychiatric hospitals, and health professionals such as psychologists, psychiatric social workers and social workers. It should also include other agencies which provide mental health services, such as family planning, family services, family counseling, courts and lawyers. Physicians should think in terms of the types of services their patients need, rather than medical diagnostics. They should refer their patients to proven mental health professionals or facilities which are competent and capable of handling a wide variety of emotional problems. The pressure of practice of most physicians generally does not permit them treatment time to devote to serious mental health disorders. By referring patients, and communicating with the referral facility or agency, good, relevant teamwork is possible.

Part of the confusion in regard to services to the mentally ill is the isolation of many of the components from each other. All institutions, agencies and professionals should attempt to close the gap between them.

Another obstacle to be overcome is the doctors' reluctance to refer to anyone other than another physician. It is important that physicians play a greater role in preventive programs, both in direct dealings with their own patients and indirectly with schools, churches and communities. Physicians should support the role of the community mental health clinics and the entire mental health spectrum by establishing good rapport and communication with these agencies. The best and most inexpensive mental health care should be within the local community, and physicians should strive to see that their communities have these resources and facilities. Too frequently in the past we have isolated the emotionally ill from their homes, families, jobs and communities in facilities away from home.

(Doctor Cohn is in general practice and is chairman of the Northeast Michigan Mental Health Board under P.A. #54.)

Kenneth E. Rowe, M.D.
Laurium

My answer to the question is going to be that of a person interested in delivery of public health services in a rural area. After observation of delivery of mental health services in the same area I would make the following suggestions which might better insure delivery of mental health care.

1. More emphasis can be shifted to the training of the family physician who still delivers the bulk of mental health care. The family doctor can take care of many of the problems and work actively in preventive aspects of mental health before patients require more complex hospital care.

2. The Act 54 Mental Health Clinic staffs in many areas can be expanded and scope of services improved by this expansion. Closer affiliation between the local hospitals and the staffs of the mental health clinics would allow for the treatment of the patient with mental illness in the local setting rather than in more complex facilities.

3. The services offered by the state mental hospitals can be expanded so that all geographical areas are covered by at least basic mental health inpatient services. This will require the outlay of more money and the recruitment of staff, both of which are difficult to come by in the present situation. Closer coordination of follow-up care of discharged patients with the local doctor, the

(Continued on Page 749)

I love my family.
I adore this house.
My in-laws are great.
The neighbors are wonderful.

Indications For use in management of anxiety and tension occurring alone or as accompanying symptom complex to medical and surgical disorders and procedures. Though not a hypnotic, fosters normal sleep through antianxiety and related muscle-relaxant properties

Contraindications History of sensitivity to meprobamate

Important Precautions. Carefully supervise dose and amounts prescribed, especially for patients prone to overdose themselves Excessive prolonged use has been reported to result in dependence or habituation in susceptible persons, as alcoholics, ex-addicts, and other severe psychoneurotics After prolonged excessive dosage, reduce dosage gradually to avoid possibly severe withdrawal reactions Abrupt discontinuance of excessive doses has sometimes resulted in epileptiform seizures

Warn patients of possible reduced alcohol tolerance, with resultant slowing of reaction time and impairment of judgment and coordination

Reduce dose if drowsiness, ataxia or visual disturbance occurs, if persistent, patients should not operate vehicles or dangerous machinery

Side Effects include drowsiness, usually transient, if persistent and associated with ataxia, usually responds to dose reduction, occasionally concomitant CNS stimulants (amphetamine, mephentermine sulfate) are desirable. Allergic or idiosyncratic reactions are rare, but such reactions, sometimes severe, can develop in patients receiving only 1 to 4 doses who have had no previous contact with meprobamate Previous history of allergy may or may not be related to incidence of reactions Mild reactions are characterized by itchy urticarial or erythematous maculopapular rash, generalized or confined to groin Acute nonthrombocytopenic purpura with cutaneous petechiae, ecchymoses, peripheral edema and fever have been reported. One fatal case of bullous dermatitis following intermittent use of meprobamate with prednisolone has been reported. If allergic reaction occurs, meprobamate should be stopped and not reinstituted Severe reactions, observed very rarely, include angioneurotic edema, bronchial spasms, fever, fainting spells, hypotensive crises (1 fatal case), anaphylaxis, stomatitis and proctitis (1 case) and hyperthermia Treat symptomatically as with epinephrine, antihistamine and possibly hydrocortisone. Aplastic anemia (1 fatal case), thrombocytopenic purpura, agranulocytosis and hemolytic anemia have occurred rarely, almost always in presence of known toxic agents. A few cases of leukopenia, usually transient, have been reported on continuous administration

Meprobamate may sometimes precipitate grand mal attacks in patients susceptible to both grand and petit mal. Extremely large doses can produce rhythmic fast activity in the cortical pattern. Impairment of accommodation and visual acuity has been reported rarely After excessive dosage for weeks or months, withdraw gradually (1 or 2 weeks) to avoid recurrence of pretreatment symptoms (insomnia, severe anxiety, anorexia). Abrupt discontinuance of excessive doses has sometimes resulted in vomiting, ataxia, tremors, muscle twitching and epileptiform seizures. Prescribe very cautiously and in small amounts for patients with suicidal tendencies Suicidal attempts have resulted in coma, shock, vasomotor and respiratory collapse and anuria Excessive doses have resulted in prompt sleep, reduction of blood pressure, pulse and respiratory rates to basal levels, and occasionally hyperventilation. Treat with immediate gastric lavage and appropriate symptomatic therapy. (CNS stimulants and pressor amines as indicated) Doses above 2400 mg /day are not recommended

Composition. Tablets, 200 mg and 400 mg. meprobamate. Coated Tablets, WYSEALS* EQUANIL (meprobamate) 400 mg (All tablets also available in REDIPAK* [strip pack], Wyeth.) Continuous-Release Capsules, EQUANIL L-A (meprobamate) 400 mg.

The young homemaker: her underlying anxiety and tension can surface and intensify under the continuous stress of rearing a growing family Especially when she's confined to the home an its environs so much.

You can help her over the rough spots with reassurance and counse Equanil can help relieve tension, ease anxiety— with little risk of serious side effects. Time and experience will probabl do the rest.

Equanil®
(meprobamate

Wyeth Laboratories
Philadelphia, Pa.

I'll scream
f I don't get away!

Photo professionally posed

health department, and the mental health clinic would improve their care.

4. A very important aspect of improving the delivery of health care is that the consumer understand what care is available, where, and under what circumstances. There must be a continuing program of public education which will make clear in the public's mind what services are available locally, regionally, and who has the responsibility for providing these services.

(Dr. Rowe is Director of the Western Upper Peninsula District Health Department.)

Lawrence W. Stieglitz, M.D.
Kalamazoo

It is a myth to assume that an efficient, effective system for delivery of mental health care services is possible at the present time.

Will solutions come from those of us who make the major part of our income from human distress, disturbance, disease, divorce, disaster and death?

What do we do about the many mental health workers who have only a superficial understanding of the dynamic unconscious: What to do about the laymen and policy-makers who are excessively influenced by the myth-makers?

The myth-makers publicized the Bridie Murphy reincarnation bit but who knows that G. M. Carstairs said, "There is no evidence that the work of child guidance with the patients or with their parents has made any difference to the attack rates of neuroses or psychoses in any community." Who knows that N. Kiell wrote, "It is my thesis that the great internal turmoil and external disorder of adolescence are universal and only moderately affected by cultural determinants."

Our outpatient treatment programs are generally for the basically healthy people. Generally, the sick get: untreatable; hospitalize; medicate or I'll sent a report.

I could go on and on but here are some suggestions:

a) premarital workshops on adolescent hangups, family planning and parenthood;

b) individualized school programming and elementary vocational training;

c) mental health seminars for ministers, teachers and parents;

d) elementary school courses on psychological principles, and

e) more psychiatric participation in the preparation of mental health case workers.

It is tragic to watch bewildered public officials asking for help from those who have so little understanding of the dynamic unconscious forces in human misbehaviour.

(Dr. Stieglitz is a practicing child psychiatrist.)

Should Medical Schools Assume Central Role?

"Your opinion please" is a monthly feature in *Michigan Medicine* designed to provide a forum for the views of Michigan physicians on vital issues. Your comments are invited in response to the questions asked on these pages.

A topic is selected each month and interested physicians are urged to send in their reactions. Letters in response to the subject for the November issue must be received in the MSMS office by Oct. 1.

The November question will be:

"Do you believe the medical schools should assume the central role not only in the education of physicians but also in determining the nature and quality of health care services provided to the community?"

Mufid Al-Najjar, M.D.
Northville

What we need to insure better delivery of mental health services is to arrange a better follow up for patients who have been already treated in one of the psychiatric facilities.

To provide this, I think our work should be concentrated on finding some kind of service that observes the patient closely as far as his regular use of medication, his functioning successfully in his community, his relation to his family and other people, his working habits, and his keeping his medical appointments when necessary.

This can all be achieved by assigning officers that have backgrounds in social work and family dynamics studies in addition to good knowledge about mental health, to visit the patients regularly as necessary and to serve as a communication between the patient and his doctor. In the meantime, the officer can provide a better understanding between the patient and the people that he comes in contact with (e.g., family, employer and friends). Such services could be backed by the community mental health facilities which in turn will provide the medical and psychiatric consultations and readmission of patients to the hos-

(Continued on Page 781)

Each 5 cc. contain
erythromycin estolate
equivalent to 250 mg.
erythromycin base.

When mixed as directed,
each 5 cc. will contain erythromycin
estolate equivalent to 125 mg.
erythromycin base.

When mixed as
directed, each cc.
will contain
erythromycin estolate
equivalent to 100 mg.
erythromycin base.

Each 5 cc. contain
erythromycin estolate
equivalent to 125 mg.
erythromycin base.

Each tablet contains
erythromycin estolate
equivalent to 125 mg.
erythromycin base.

The many
forms
of Ilosone®

Erythromycin Estolate

Lilly

Additional information
available upon request.
Eli Lilly and Company
Indianapolis, Indiana 46206

Each Pulvule® contains
erythromycin estolate
equivalent to 125 mg.
erythromycin base.

Each Pulvule contains
erythromycin estolate
equivalent to 250 mg.
erythromycin base.

Heroin Addiction

A Comparison Of Two Inpatient Treatment Methods

By Maurice L. LaRouche, M.D.
Patrick T. Donlon, M.D.
Detroit

Heroin addiction has been a medico-legal-social problem in the United States since the Civil War. By the turn of the century there were an estimated 264,000 addicts in America.[1]

The Harrison Narcotic Act of 1914 made the non-medical use of opiates illegal. Unfortunately, this Act indirectly led to the underground distribution of heroin and the resultant two major moral changes to which nearly all heroin addicts must consent.

The first is to accept the consequences of the tremendous financial burden of supporting an addiction. As tolerance to heroin develops the addict must pay increasing amounts of money to sustain his habit. Soon he is unable to function at his regular employment and to meet other financial obligations, such as providing for his family.

Because a habit may cost up to $250.00 a day for chronic abusers, the addict must find new ways of obtaining large sums of money. A street life of "hustling" consisting of stealing, pimping, prostituting, drug pushing, and other anti-social activities soon becomes a major part of the addict's existence. Long term goals are secondary. Maintaining the addiction is the ultimate concern. Police arrests and incarcerations are frequent.

Secondly, the addict commits himself to ill health and for many, premature death. Death from overdosage and danger of serious infections are a constant reality. They result from a contaminated drug supply, non-sterile intravenous technique, and ignorance of the dosage injected.

Adding to the seriousness of the problem, according to records, the incidence of heroin addiction is rapidly increasing both in Metropolitan Detroit and throughout Michigan (**Table 1**). There is also evidence that it is spreading from the more culturally deprived populations to other socio-economic groups.

Table I

Incidence of Heroin Addiction*

	New narcotic addicts reported	Heroin addicts arrested in Detroit
1965	75[1]	328
1966	99[1]	451
1967	137[1]	509
1968	357[2]	1027
1969	987[2]	1691

[1] New heroin addicts reported in Michigan
[2] New addicts reported in Detroit

The prevalence of heroin addiction in Michigan remains unknown. Estimates extend up to 10,000 addicts in Metropolitan Detroit alone. Striking is the rising incidence of new addicts being reported in Michigan each year and the number of heroin addicts being arrested in Detroit. Both categories in **Table 1** are composed primarily of those abusers who have criminal records but the figures do reflect the trend towards rising heroin abuse.

Unfortunately, psychiatric treatment approaches have never been completely satisfactory. Outpatient uncovering psychotherapy alone seems of limited value. The follow-up statistics on patients treated at NIMH Hospital in Lexington, Kentucky, are most discouraging. According to one study, approximately 90% of these patients are readdicted within six months following discharge.[2] It seems likely that this recovery rate will improve with the development of a more comprehensive aftercare program.

scientific papers

Doctor LaRouche is a third-year resident and Doctor Donlon is a member of the junior staff at the Lafayette Clinic, Detroit.

*We wish to thank Detective Inspector Joseph Brown, Narcotic Bureau, Detroit Police Department, and Federal Agent Ronald Metcalf, Federal Narcotics Bureau, Detroit, Michigan for supplying the statistical data.

Table II
Selectivity Scale Scores

Patient	Sex	Age When Hospitalized	Duration of Addiction	Drugs	Occupational	Civil	Family	Ego Maturity	Motivation	Total
Group A Conventional (non-Medical) Treatment										
1.	F	38	15 months	1	0	0	0	1	0	2
2.	M	31	14 years	0	1	0	1	1	1	4
3.	M	24	6 years	0	0	0	0	1	0	1
4.	F	32	14 years	0	0	0	0	1	1	2
5.	M	31	14 years	0	1	0	0	1	1	3
6.	M	22	8 months	1	2	2	1	1	2	9
7.	F	33	14 years	1	0	0	0	1	1	3
8.	M	18	8 months	1	1	2	2	1	1	8
9.	M	40	14 years	1	1	0	1	1	1	5
10.	M	23	3 years	1	1	0	1	1	0	4
Group Averages		29.2	8.2 years							4.1
Group B Methadone Maintenance										
1.	M	29	2 years	0	0	0	1	0	0	1
2.	M	34	5 years	0	1	0	0	1	0	2
3.	M	32	2 years	0	1	1	0	0	1	3
4.	M	38	15 years	1	1	1	1	1	2	7
5.	M	24	3 years	0	1	2	1	1	1	6
6.	M	41	7 years	1	2	2	1	1	2	9
7.	M	32	6 years	1	1	2	1	1	2	8
8.	M	35	6 years	2	2	2	2	1	2	11
9.	M	37	9 years	1	2	1	1	1	2	8
10.	M	33	7 years	1	1	0	1	1	1	5
Group Averages		33.5	6.1 years							6

The British system allows for "registered" addicts to be dispensed opiates. Nonetheless the incidence of heroin addiction in Britain continues to increase. Synanon, with its family style, has proven beneficial to a certain group of addicts who can adjust to the "community rules."

Medical treatment has been more successful. In 1964, Dole and Nyswander in New York City initiated methadone maintenance treatment. They found that methadone when given in a single oral daily dosage of 50-100 mgs. blocks both the craving for opiates and the psychophysiological "high" experienced by addicts when "shooting" heroin. By 1968 they reported successfully treating 750 criminal heroin addicts. Eighty-eight percent of their patients were arrest-free after beginning treatment.[3] Although these patients were initially hospitalized, ambulatory treatment alone is also therapeutic. The opiate antagonists, cyclazocine and naloxone, have proven to be therapeutic in clinical trials and may play an important role in the treatment of addicts in the future.

Procedure

The Lafayette Clinic is a 160-bed neuro-psychiatric clinic located in downtown Detroit. It is operated by the Michigan Department of Mental Health and is the major teaching hospital in psychiatry for Wayne State University School of Medicine. This study was conducted on two inpatient populations of heroin addicts with the exception of a patient in Group B who remained an outpatient. Each group consisted of 10 patients.

Patients in Group A were the participants in a retrospective and prospective study of the traditional non-medical form of inpatient psychiatric treatment. Group B formed a prospective study of methadone maintenance treatment (**Table II**).

Group A. Traditional Treatment

These 10 patients were admitted during the years 1964-69. All were voluntary admitted patients who expressed an interest in psychiatric treatment and being drug free. Seven were males, three females. The average age was 29.2 years; average duration of addiction was 8.2 years; and with the exclusion of one patient who was hospitalized for 14 months, the average hospital stay was 6 weeks. Treatment consisted of medical substitution withdrawal with methadone over a one to two week period, psychotherapy, milieu therapy, social service casework with the family when indicated, and rehabilitation planning. Precautions were taken so that drugs would not be available to the patients during their hospitalization. Most of the patients were hospitalized on a locked ward.

Group B. Methadone Maintenance Treatment

Following the protocol established by Dole and Nyswander, a methadone maintenance program was initiated in March, 1969, as a pilot project. The patients were admitted in pairs and remained hospitalized for six weeks. One patient transferred from the New York program and remained an outpatient. The average age was 34 years; average duration of heroin addiction was 6.1 years. All of the patients were considered "hardcore" addicts. The first three patients were not stringently selected. It became apparent soon after their hospitalization that the treatment program as described was not sufficient to satisfactorily treat their addiction. For this reason a Selectivity Scale was developed (**Table III**) so that the remaining candidates could be more highly screened.

Treatment was primarily medical. At the time of hospitalization the patients were placed on methadone and the dosage was increased gradually as tolerance developed to a maintenance level. This maintenance level was found to block both the craving for the opiates and the psychophysiological "high" if opiates were taken concurrently with the methadone. The daily dosage ranged from 40-100 mgs. at the time of discharge. Psychotherapy was predominantly reality-oriented, and no attempt was made at long-term uncovering psychotherapy. The patients were hospitalized on an unlocked general psychiatric ward with 28 other psychiatric patients. Visiting privileges and passes were given relatively liberally. Weekly group psychotherapy sessions were begun in September, 1969, for the methadone maintenance patients.

Following discharge the patients reported daily to the clinic to take their methadone and to leave a urine sample – both performed under the observation of a staff member. The urine was tested for opiate derivatives, quinine, amphetamines, and barbiturates. Members of the staff talked with the patients daily to give support and guidance.

Selectivity Scale

Beginning with the third patient in group B it became apparent that methadone maintenance treatment alone is not sufficient for treating all heroin addicts. Patient selection seemed equally important especially when only a modest aftercare program is available. The Selectivity Scale was devised as a further screening tool with the hypothesis that it might be of some prognostic value. The Scale evaluates the patient in six different areas: civil, occupational, drug abuse history (including alcohol), emotional and financial family involvement, emotional maturity, and motivation for treatment. In each area a rating of poor is scored as 0, fair as 1, and good as 2. It was hypothesized that, in general, there was a direct relationship between the patient's total score (as shown in **Table II**) and his treatment prognosis with methadone maintenance. Beginning with the fourth patient in group B, the next seven patients accepted for the group had a total Scale score of at least 5.

Table III

Selectivity Scale

Civil		
	0	A felony or more than 5 convictions
	1	Misdemeanors or probation
	2	Legally free
Occupational		
	0	Never employed for one year period
	1	Fair work record
	2	Presently working
Drugs		
	0	Multiple drugs or alcohol
	1	Heroin alone
	2	Generally free of drugs
Family		
	0	All contacts broken
	1	Still married or living with family
	2	Providing for family or wife
Maturity		
	0	Psychotic, brain damaged, marked sociopathic
	1	Emotionally unstable, immature, impulsive
	2	Mature, responsible, adaptable
Motivation		
	0	Pressured by family or law for treatment
	1	Attempted treatment before
	2	Well motivated presently

Results

Group A. Traditional Treatment

The patients were retrospectively given a total score on the Selectivity Scale. These ranged from 1 to 9 with an average of 4. Three of the patients signed themselves out Against Medical Advice (A.M.A.) All of the patients displayed some irritability after their opiate withdrawal. Their cooperation with the milieu and psychotherapist was at times marginal. Many became demanding and manipulative. In turn, this behavior elicited some negative attitudes from the staff. All of the patients except one who entered jail at the time of discharge and the three who signed out A.M.A. were offered continued outpatient psychotherapy. In all cases this treatment was unsatisfactory. On follow-up all 10 patients were found to be readdicted.

Group B. Methadone Maintenance Treatment

The first three patients, although initially cooperative, soon began showing signs of progressive return to their drug usage patterns and to the company of addicted peers. All three continued to frequently abuse drugs after the inpatient stage and were subsequently released from the study. The remaining seven, however, have responded favorably and are currently involved in the aftercare program. Further experimentation with heroin has been infrequent. As of this date (January 15, 1970) all but one are gainfully employed. There have been no further police arrests. Family relations are improving. The morale of the group is considered high.

Discussion

The 10 heroin addicts in Group A were medically withdrawn from their addiction and given traditional non-medical inpatient psychiatric treatment. All became readdicted following discharge. Their total Selectivity Scale scores given retrospectively were of no prognostic value. However, the highly-selected "hard-core" heroin addicts in Group B treated with inpatient supportive reality oriented milieu, counseling, and methadone maintenance have responded favorably. The failure of the first three patients in Group B is felt to be more related to a lack of patient motivation and the limited therapeutic and aftercare facilities of the project than to negative emotional attitudes of the staff. The blocking of the craving for opiates and the patient's inability to get "high" on the opiates when on daily methadone is felt to be most significant.

The Selectivity Scale is considered to have some prognostic value for patients treated with methadone maintenance. The best candidate for methadone maintenance treatment appears to be one who has a respectable occupation and civil record, drug abuse history involving only heroin but for at least a four year duration, financial and emotional family commitments, emotional maturity, and a sincere motivation for treatment.

It must be stressed that methadone, like heroin, is an addicting drug. Its advantage over heroin is that it may be taken orally thus eliminating the medical problems associated with intravenous injection. Methadone in no way eliminates an individual's drive towards criminal behavior if present, but when properly administered the addict is no longer compelled to sociopathy to finance his heroin addiction. The wide scale administration of methadone to all heroin addicts seems impractical. Many addicts simply do not wish to be free of their habit. Addicting the youthful addict to methadone also requires an important ethical judgment. Abstinence symptoms from methadone are severe. The indiscriminate prescribing of methadone to heroin addicts has little therapeutic value. The addict infrequently takes his prescribed methadone unless rapport has been established with a treatment facility and he is seen daily. Methadone maintenance treatment is only successful when it is a part of a carefully planned and adequately staffed therapeutic and rehabilitative program.

When less highly selected or purely ambulatory heroin addicts are treated with methadone maintenance a more comprehensive aftercare program than that described above becomes imperative. This should include psychotherapy and family services when indicated, legal counseling, and rehabilitative resources such as halfway houses, job training programs and job placement. At the present time, treatment facilities for heroin addiction are very limited in the State of Michigan. When addicts turn for help, they frequently find sparse resources. Although probably not all addicts are amenable to rehabilitation, the authors believe that a significant percentage of addicts would respond favorably to treatment if therapeutic facilities were made available.*

---

*The methadone maintenance study is one of the pilot studies currently being conducted at the Lafayette Clinic for the treatment of heroin addiction. The knowledge and clinical experience gained in these studies will be used for the treatment of larger numbers of addicts in the future, providing that adequate funding is available.

References

1. Kolb, L: Drug Addiction: A Medical Problem. Springfield, Ill., Charles C Thomas, 1962.
2. Hunt, G. H., and Odoroff, M. E. Follow-up study of narcotic drug addicts after hospitalization. Public Health Rep. 77:41, 1962.
3. Dole, V. P., Nyswander, M. E., and Warner, A. Successful treatment of 750 criminal addicts. J.A.M.A. 206:2708-2711, 1968.

From the Hospital

Early Postoperative Discharge Of Patients

By Paul T. Lahti, M.D.
Royal Oak

Synopsis-Abstract

Records kept on 1,114 consecutive surgical procedures confirm that early postoperative discharge of patients from the hospital is not only possible but is desirable.

Data on number of cases and day of discharge show that 75% went home on or before the second postoperative day.

Included in the percentage for 1,114 consecutive patients were all procedures except for gastric surgery, bowel resections, trauma, and minor surgery.

Of the 1,114 patients, only four were readmitted to the hospital — two for four days and two for three days. Early postoperative discharge is beneficial: to the patient for both health and financial reasons; to the surgeon, in time saved; to the hospital, in better utilization of facilities; and to the insurance companies, in decreased expense.

Education of the patient, hospital staff, family, and employers as to the benefits of early discharge is essential for the success of the program.

Early ambulation of postoperative patients was popularized by Doctor D. J. Leithauser[1] in 1941. Before early ambulation, patients more frequently died from pulmonary embolus, pneumonia, and other complications. It took several weeks to recuperate from the surgery. Recovery was slow, not from the surgical trauma, but from the prolonged period of inactivity and bed rest. If without surgery, a healthy person were put to bed for a week and given narcotics at intervals, it would take several weeks to recover from this experience.

Since 1941, the period of hospitalization necessary after surgery has decreased steadily. Following early ambulation, came the realization that early postoperative discharge from the hospital sharply decreased the period of disability and practically eliminated complications. It is now possible and desirable to discharge the majority of surgical patients on the first or second postoperative day.

Data on the number of cases, the day of discharge from the hospital, and percentages for 1,114 consecutive procedures (including all surgery except gastric, bowel resections, trauma, and minor surgery), are presented in Figures 1-10.

Comparative data on average postoperative stay are compiled from 16 million postoperative discharges from 995 hospitals that participated in the Professional Activity Study (PAS) during periods in January 1965 through June 1968. With each of the procedures in our study, we cite the PAS national average hospital postoperative stay for comparison.

Inguinal Herniorrhaphy For Unilateral or Bilateral Hernia

(Fig. 1), 377 Cases.

Of the total 377 inguinal hernia patients of all ages, 80% were discharged on or before the first postoperative day, as compared to the PAS average postoperative stay of six days. With 152 patients, age 14 and under, 143 were unilateral and nine were bilateral; 34 went home on the day of surgery, 114 were discharged on the first postoperative day, three on the second, none on the third and one on the fourth. With 225 patients, age 15 and over, three went home on the day of surgery, 148 were discharged on the first postoperative day, 49 on the second, 13 on the third, and 12 stayed four or more days.

Appendectomy for Acute, Gangrenous, or Perforated Appendicitis

(Fig. 2), 142 Cases.

Of 142 appendectomy patients (13 gangrenous, 10 perforated, and 119 acute), 82% went home on or before the second postoperative day. PAS aver-

---

The author, who is senior attending surgeon at William Beaumont Hospital, Royal Oak, presented this paper at the 1970 Convention of the American Medical Association in Chicago in June. He was the only Michigan physician to present a paper there.

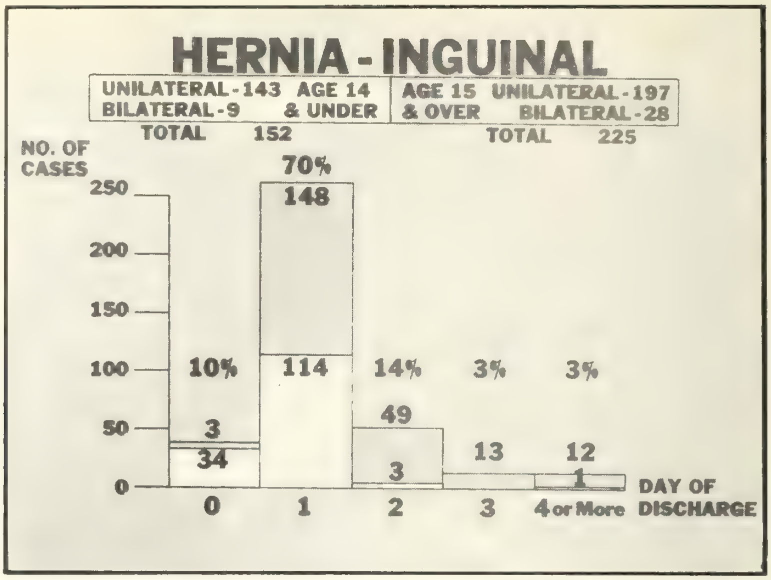


Fig. 1. — Percentage figures for day of discharge of 377 patients following inguinal herniorrhaphy for unilateral or bilateral hernia.

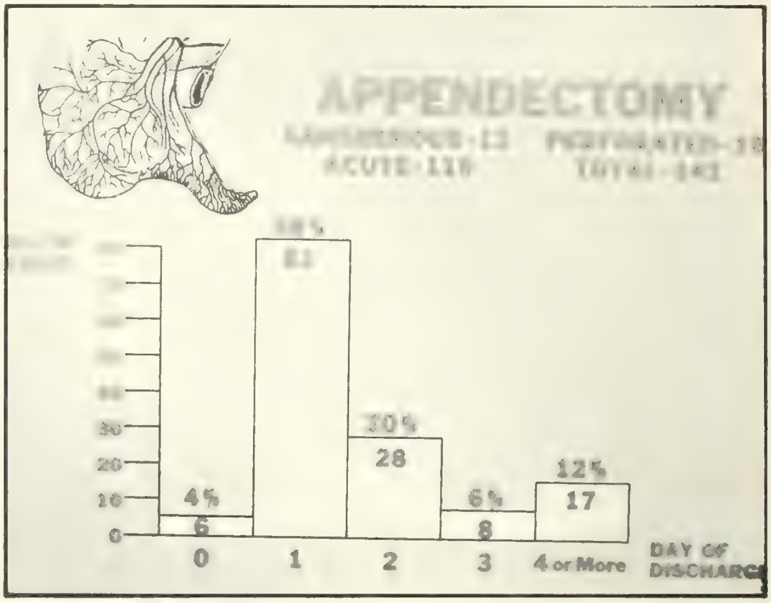


Fig. 2. — Percentage figures for day of discharge of 142 patients following appendectomy for acute, gangrenous, or perforated appendicitis.

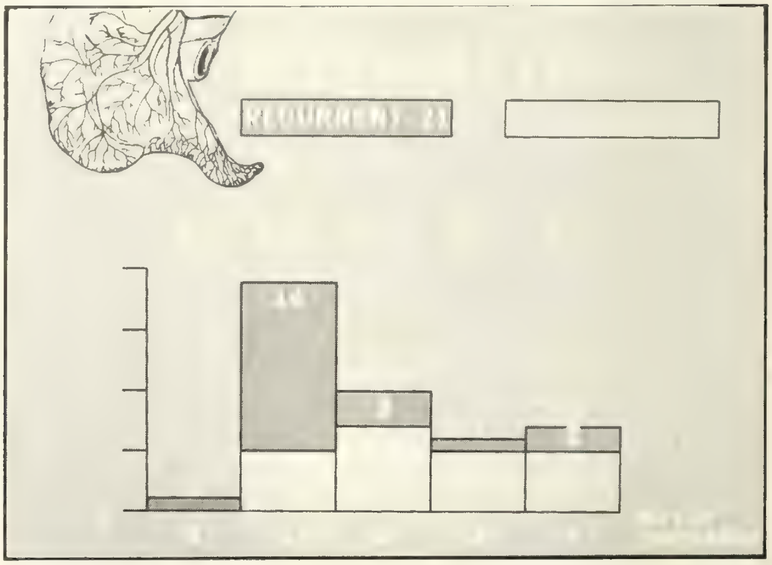


Fig. 3. — Percentage figures for day of discharge for 43 patients for recurrent or incidental appendicitis.

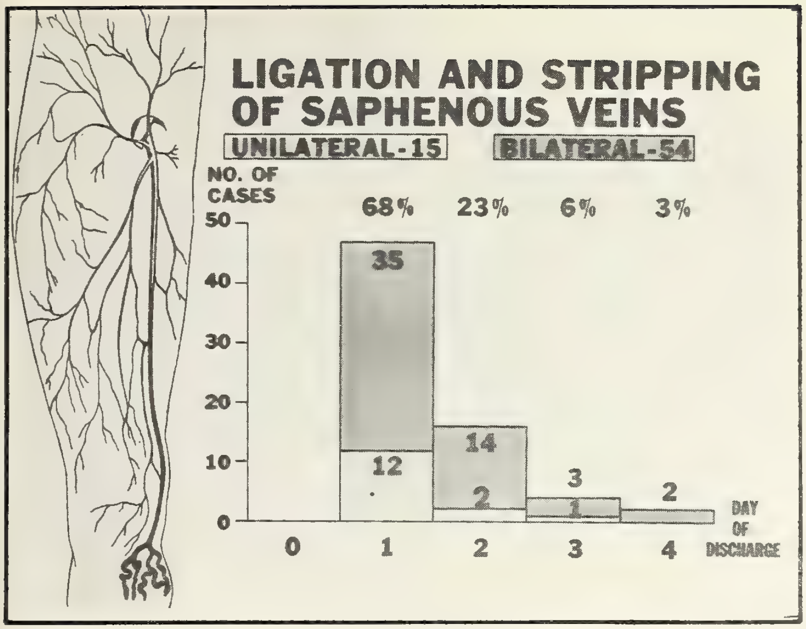


Fig. 4. — Percentage figures for day of discharge for 69 patients with unilateral or bilateral ligation and stripping of the saphenous veins.

age postoperative stay is six days for appendectomy. Of the total in our series, six patients were discharged on the same day as surgery; 83 went home on the first postoperative day, 28 on the second, eight on the third, and 17 on the fourth or longer day.

With 43 recurrent or incidental appendectomy patients, 70% were discharged on or before the second postoperative day, and the remaining 30% by the fourth day (Fig. 3).

Ligation and Stripping Of The Saphenous Veins

(Fig. 4), 69 Cases.

Of the total 69 patients, 15 were unilateral and 54 were bilateral. Ninety-one percent were discharged on or before the second day. PAS reports the average day of discharge for ligation and stripping is the fifth day.

Hemorrhoidectomy

(Fig. 5), 70 Cases.

Of the 70 hemorrhoidectomy patients, eight were discharged on the first postoperative day; 28 on the second day, 14 on the third, and 20 on the fourth. The majority of these patients were discharged on or before the second day. PAS average postoperative stay is six days.

Pilonidal Cystectomy

(Fig. 6), 27 Cases.

Of 27 pilonidal cyst patients, 97% were discharged on or before the second postoperative day. Only one patient stayed four days. PAS postoperative stay is four days.

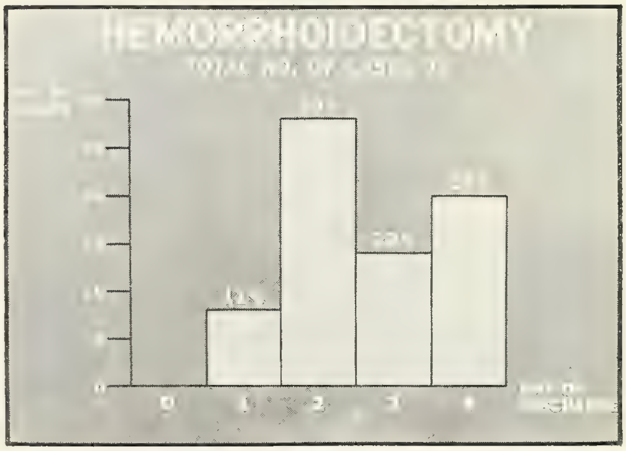


Fig. 5. — Percentage figures for day of discharge for 70 patients with hemorrhoidectomy.

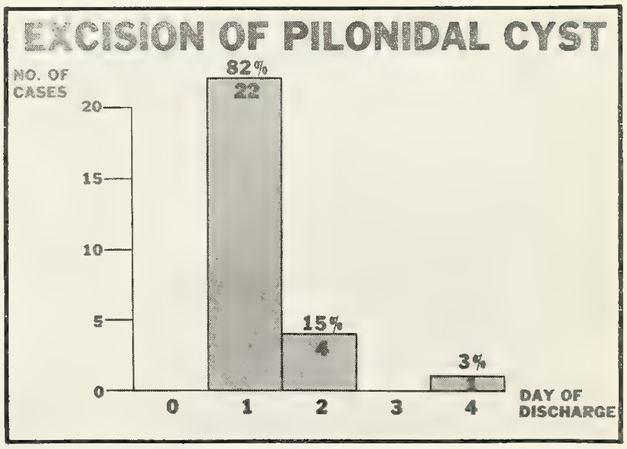


Fig. 6. — Percentage figures for day of discharge for 27 patients with pilonidal cystectomy.

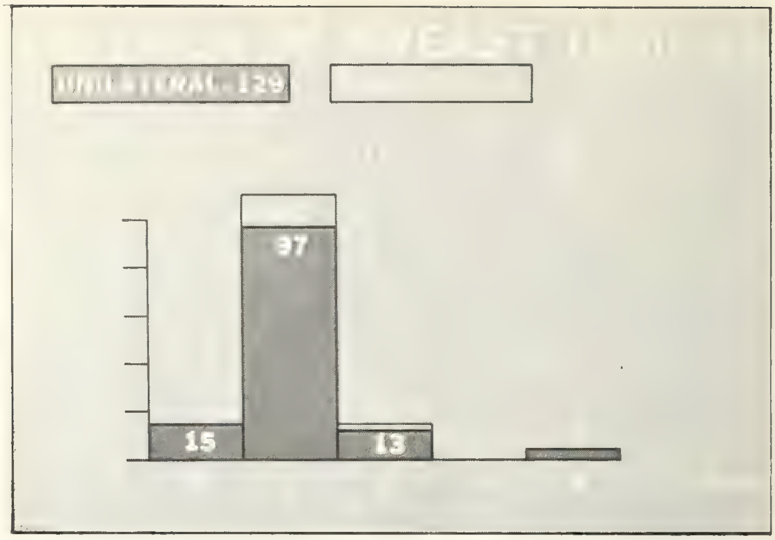


Fig. 7. — Percentage figures for day of discharge for 142 patients with unilateral or bilateral excision of breast tumors.

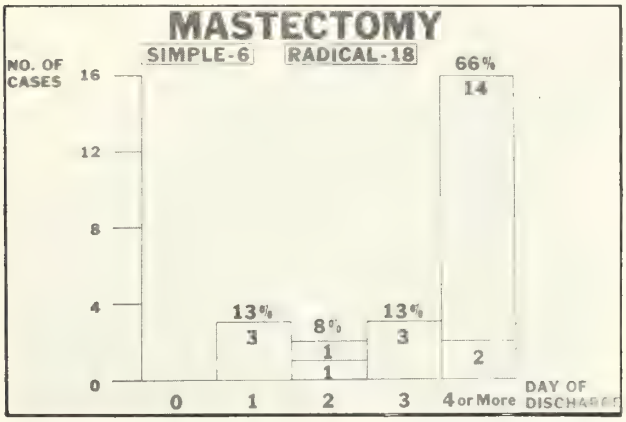


Fig. 8. — Percentage figures for day of discharge for 24 patients with simple or radical mastectomy.

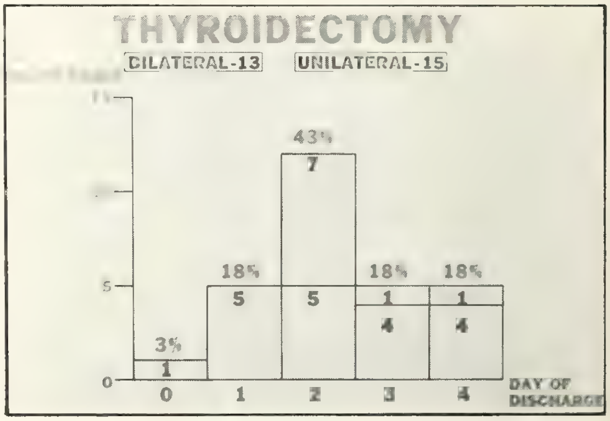


Fig. 9. — Percentage figures for day of discharge for 28 patients with unilateral or bilateral thyroidectomy.

Excision of Breast Tumors

(Fig. 7), 142 Cases.

Of the 142 patients with excision of breast tumors, 129 were unilateral and 13 were bilateral. Ninety-eight percent were discharged on or before the second postoperative day. The remaining 2% went home on the fourth day. PAS average postoperative stay is three days.

Mastectomy, Simple and Radical

(Fig. 8), 24 Cases.

With 24 mastectomy patients, six were simple and 18 were radical. Of the total, 34% went home on or before the third postoperative day. The remaining 66% were discharged on the fourth through the seventh day. PAS average postoperative stay is seven days for simple mastectomy and 14 days for radical mastectomy.

Thyroidectomy

(Fig. 9), 28 Cases.

With 28 thyroidectomy patients, 15 were unilateral and 13 were bilateral; one went home on the day of surgery, five on the first day, 12 on the second, five on the third, and five on the fourth day. Of the total 28 patients, 64% went home on or before the second postoperative day. PAS average postoperative stay is six days.

Cholecystectomy and Cholecystotomy

(Fig. 10), 150 Cases.

Of 150 cholecystectomy patients with a diagnosis of acute, chronic, or subacute, 42% were discharged on or before the third postoperative day. None stayed longer than seven days. PAS average postoperative stay is 10 days.

Of the total 1,114 consecutive patients, 75%

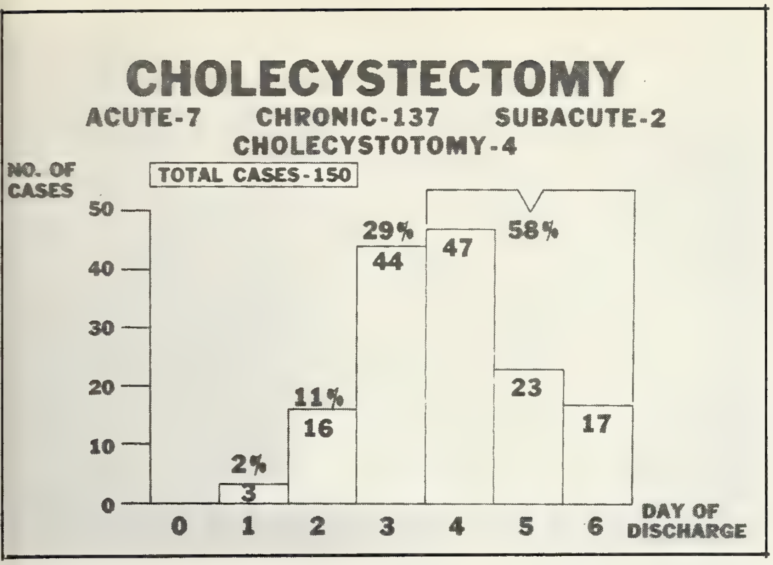


Fig. 10. — Percentage figures for day of discharge for 150 patients with cholecystectomy or cholecystotomy.

went home on or before the second postoperative day (**Fig. 10**).

The usual patient entering the hospital for major surgery is frightened of the unknown. He is told that he will be in the hospital for several days. He interprets this to mean that he will be ill. When he awakens from the anesthetic, his fears are all brought to the surface. Any minor discomfort is magnified into real pain. Narcotics only prolong the recovery.

In contrast, the patient who knows that he will be up and about the afternoon of surgery and home the day after surgery is relaxed, not fearful, and requires much less postoperative medication. Infants and young children have not been conditioned to being ill following surgery and as a result, they usually are not.

For this routine to work successfully, the following points are necessary.

1. The surgeon must believe in it himself.

2. This confidence in the procedure must be transferred to the patient preoperatively.

3. The patient must be encouraged to be up and around immediately on awakening from the anesthetic. This relieves most of the postoperative spasm and the pain.

4. The nurses must be instructed in the avoidance of narcotics. Usually, for an adult, one or two doses of 50 mg of Demerol is sufficient.

5. The patient must be given a mild analgesic to relieve the normal amount of discomfort.

6. If a patient is reluctant to go home, it is helpful to explain to him that as soon as the need for hospitalization ceases, he is much better off at home. It is important that he knows of the small but very real incidence of postoperative complications caused by being inactive and in a hospital.

Patients readily agree that it is in their best interest and in most instances are very anxious to go home early. Because of a home situation, some patients did not go home as early as they could have. No patient is discharged against his wishes.

Upon discharge, each adult is given a prescription for an analgesic, usually Darvon with acetylsalicylic acid. Rarely does a patient use more than one or two. Most patients use only aspirin.

Each patient is seen in the office for removal of sutures on the fourth to the seventh day. He is sent home from the hospital without a dressing, unless a drain is in place, in which case he is instructed to change his dressing. He is advised to bathe daily and to wash over the sutures with soap and water.

PATIENTS ARE ADVISED that they may be up and about as much as they desire and resume normal activities, including driving. Many patients return to work before the sutures are removed.

Most of the patients in this series were able and anxious to return to work much sooner than the usual four to six weeks disability period insisted on by most employers.

In this series of 1,114 patients, there were no deaths or complications such as atelectasis, pneumonia, urinary retention, thrombophlebitis, and pulmonary embolus. Of these 1,114 patients, only four were readmitted to the hospital. Two children with a diagnosis of gangrenous appendix were treated with oral antibiotics and released after four days. Following a thyroidectomy, one patient was readmitted because of edema about the wound. He was hospitalized for three days with no treatment other than observation. These occurred early in the series. Wound disruption

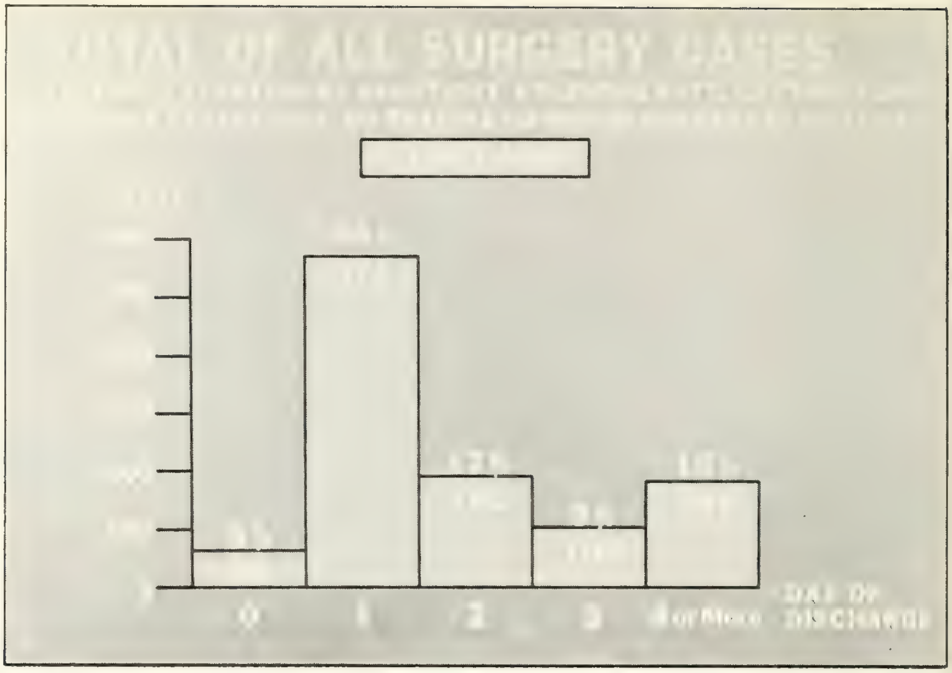


Fig. 11. — Percentage figures for day of discharge for total of 1,114 patients by length of postoperative stay.

occurred in one obese, diabetic male patient who, after secondary closure, was discharged again on the third day.

In this period of rapidly rising costs, early postoperative discharge of patients offers a method of decreasing hospital costs by at least 30%.

In 1968, a survey conducted by the Health Insurance Association of America showed that each person discharged a day sooner from the hospital would save at least $61; and the insurance companies, about $1.7 billion annually. The average hospital stay, according to the survey, was 8.4 days. In our study, with the listed procedures, all patients were discharged by the seventh postoperative day; 75% of the 1,114 patients were discharged by the second day.

Today this program, which shortens the hospital stay by three to four days, would save the patient at least $200 and the insurance companies at least 4 billion annually. In addition, there are great savings in sick-leave compensation and in fewer man-hours lost to the economy. It also saves the surgeon time in hospital rounds.

This method works. It is not in the experimental stage. It has been used on several thousand patients. There are no valid reasons for keeping a patient in the hospital any longer than is necessary to recover from the anesthetic, in the usual case.

The fear that "something might go wrong" if he goes home is now changed to "something might go wrong" if he stays in the hospital.

It is difficult to overcome the traditions and habits of the past, but the results are certainly worth the effort.

Reference

1. Leithauser, D. J. and Bergo, H. L.: Early rising and ambulatory activity after operation. Arch. Surg. 42:1086, 1941.

A Preventable Cause of Death

Air Embolism Following Open Heart Surgery

By Walter H. Janke, M.D., F.A.C.S.
Ali A. Esfahani, M.D., F.A.C.S.
Flint

Unconsciousness and deep coma secondary to cerebral embolism following "open heart" surgery constitute one of the dreaded complications of this type of surgery. These patients will routinely need tracheostomy to maintain ventilation, vasopressors to improve cardiac output, and feeding tubes to maintain nutrition. On occasions some of them will recover, the majority, however, will have a fatal outcome. Even though embolization of fat, clots, or calcium debris have on occasions been found, air embolism, however, is the recognized cause in the greatest majority of these cases.

Based on our experience with 113 cases in which total cardiopulmonary bypass was utilized without occurrence of this complication, we feel that air embolism is not only preventable, but that deep coma secondary to air embolism should not be a complication of "open heart" surgery, if careful steps are taken during and at the completion of cardiopulmonary bypass.

Of these 133 patients, all of them were fully awake in the recovery room, with the exception of one patient who had severe hypotension following occlusion of the left main coronary artery after an aortic valve replacement and mitral commissurotomy. In all the others which included 58 single valve replacements, four double, and one triple valve replacement, the patients were all awake at the termination of surgery.

Of these 63 patients, 11 (17%) eventually died from various complications during their hospitalization. Fifty-two patients (83%) left the hospital after an average postoperative stay of 13 days. The clinical status of the patients prior to surgery did not seem to play a significant role in these results, since out of 29 patients in Class IV, 22 or (79%) went home. Hospitalization was prolonged, however, in these patients, with the average hospital stay following surgery being 18 days.

Technique

All cases of "open heart" surgery are performed through a mid-sternotomy. Hemodilution and normothermia are routinely employed using the femoral artery for the return of oxygenated blood from the pump oxygenator. A left ventricular sump-drain is always inserted without exception whenever surgery involves the left heart chambers. In aortic valve replacement, coronary perfusion is usually employed. Extreme care should be used to prevent air from entering the coronary vessels through the coronary perfusion cannulas. If there is good exposure through the aortic root, as is often the case in patients with aortic insufficiency, we replace the valve without the aid of coronary perfusion. Average pump run when coronary perfusion is not utilized in 45 minutes. This increases to 65 minutes when one or two coronary cannulas are used. In closing the aortic root, we feel it is extremely important to leave a central opening in the aortotomy for the elimination of air from the aortic root prior to the opening of the aortic clamp. This will obviate air in the right coronary artery which is bound to occur if this precaution is not taken. After the aortic root has been closed and partial cardiopulmonary bypass established, the left ventricular sump should be employed for several minutes before the left ventricle is allowed to overcome the pump. The left ventricle should also be elevated to eliminate all possibility of air trapped within the left ventricular cavity.

In patients with mitral valve replacement, a Foley catheter is introduced through the prosthesis and left in place until all the air has been eliminated from the left ventricular and left atrial cavities. One of the vena cava snares is released at this point to allow blood to enter the left-sided chambers. The heart is never arrested and usually it continues to beat throughout the procedure. After the left atriotomy is closed, the same maneuver is performed with the left ventricular vent as following an aortic valve replacement.

The authors are on the active staff in the Department of Thoracic Surgery at McLaren General Hospital, St. Joseph Hospital, and Hurley Hospital, Flint.

Excellent heart action following cardiopulmonary bypass is the rule, and the patient should be fully awake soon after the anesthetic agents are discontinued. Carbon dioxide flooding of the operative field and cardiac fibrillation have not been used.

Discussion

Coma secondary to cerebral embolism is a recognized complication following "open heart" surgery. Although many causes have been attributed to it, one fact is clear, unless all air is evacuated from the heart at the completion of cardiopulmonary bypass and prior to the time when the left ventricle is allowed to overcome the pump, air present in the left ventricular cavity will find its way into the systemic circulation and end up in the carotid vessels, the coronary vessels, or both. If it enters the carotid vessels, neurological abnormalities of a variable degree to deep coma will occur. If it enters the coronary vessels, myocardial ischemia with secondary low cardiac output and, frequently, ventricular arrhythmias will be present. We are certain that this complication is avoidable if careful and well thought steps are taken at the completion of cardiopulmonary bypass. The use of a left ventricular vent in procedures that involve the left sided chambers is probably the best way of removing air from them. Its use, however, will not be a guarantee of freedom from this complication unless it is carefully employed. Unless blood is first allowed to fill the left-sided chambers after they have been closed but not made airtight, a vent might indeed be a way of sucking air inside the ventricular cavities.

Summary

Cerebral air embolism following "open heart" surgery is a serious complication often resulting in coma and death. We feel this is preventable if well thought steps are taken to remove all the air from the heart at the completion of cardiopulmonary bypass. Our total experience with 110 consecutive cases of "open heart" surgery without air embolism has been presented. The technique utilized emphasizing the measures to prevent air embolism is described.

References

1. Javid, H., et al: Neurological Abnormalities Following Open Heart Surgery, J. Thorac Cardiov Surg 58-502, 1969.
2. Takita, H., et al: Hyperbaric Treatment of Cerebral Air Embolism as a Result of Open Heart Surgery. J Thorac Cardiov Surg 55-682, 1968.
3. Carlson, R., Lillehei, W.: Unusual Modification of the Aortic Needle Vent for Prevention of Air Embolism During Open Heart Surgery, J. Thorac Cardiov Surg 53-848, 1967.
4. Spinner, M. P., et al: The Use of Ultrasonics in the Determination of Arteriol Air Embolism During Open Heart Surgery. Ann Thorac Surg 8-489, 1969.

INFORMATION FOR CONTRIBUTORS

1. Address scientific manuscripts to the Publication Committee, Michigan State Medical Society, 120 West Saginaw Street, East Lansing, Michigan 48823.

2. Submit original, double-spaced typewritten copy and two carbon copies or photo copies on letter size (8½ x 11 inch) paper.

3. On page one, include title, authors, degrees, academic titles, and any institutional or other credits.

4. Authors are responsible for all statements, methods, and conclusions. These may or may not be in harmony with the views of the Editorial Staff. It is hoped that authors may have as wide a latitude as space available and general policy will permit. The Publication Committee expressly reserves the right to alter or reject any manuscript, or any contribution, whether solicited or not.

5. Illustrations should be submitted in the form of glossy prints or original sketches from which reproductions will be made by **Michigan Medicine.**

6. Contributors will be notified as soon as practical if a manuscript is accepted for publication. Unused manuscripts will be returned. Every care will be taken with the submitted material but the Journal will not hold itself responsible for loss or damage to manuscripts.

7. Articles should ordinarily be less than four printed pages in length (3000 words).

8. References should conform to *Cumulative Index Medicus,* including, in order: Author, title, journal, volume number, page, and year. Book references should include editors, edition, publisher, and place of publication, as well.

9. Specify address to which galley proofs should be sent. Proofs will be mailed to authors for correction before publication and should be returned to the editor in 48 hours. If proofs approved by the author are not received by the editor prior to deadline, publication of the article will be cancelled for that issue.

10. The editors welcome, and will consider for publication, letters containing information of interest to Michigan physicians, or presenting constructive comment on current controversial issues. News items and notes are welcome.

11 It is understood that material is submitted for exclusive publication in **Michigan Medicine.**

Unusual Clinical Course in Patients With Malignant Melanoma

By William J. Foley, M.D.
William W. Coon, M.D.
Ann Arbor

Malignant melanoma is regarded as one of the most aggressive of tumors. Perhaps this is because widespread metastases and death can occur so quickly and because the patients so often are young adults in the prime of life. Yet the 5-year survival rate for malignant melanoma is considerably better than that for carcinoma of the lung or stomach. Even with distant metastasis, the outlook is not totally bleak. When the primary tumor has been controlled for a reasonable period of time, removal of isolated metastatic lesions as they occur can occasionally be of great palliative benefit. Another unusual aspect of malignant melanoma is that on rare occasions, even with widespread metastasis, the tumor may undergo spontaneous regression. Few studies of spontaneous regression of tumor have been published. Most likely, this is because the experience of any one physician or clinic is too limited. Still, spontaneous regression should be of interest to physicians because of its potential implications for the field of oncology.

This is a report of three patients with widespread metastases from malignant melanoma in whom prolonged survival occurred. One case points out the occasional value of aggressive treatment of metastases which appear after the primary has been adequately controlled. The other two patients who had spontaneous regressions of their tumors are described as a basis for discussing some of the theoretical considerations of this phenomenon in malignant melanoma.

Case Reports

Case 1

The patient is a 62-year-old white woman who noted enlargement of a mole of her left temporal area in 1942 when she was 34 years old. It was treated with radium; a histologic diagnosis was not obtained. In 1950 a palpable nodule in the left parotid area was excised. A diagnosis of metastatic melanoma in a lymph node was made; the patient received a course of radiation therapy to the area.

The patient presented at the University of Michigan Medical Center for the first time in 1952 with the recent development of motor weakness of the right side of the body and grand mal seizures. Arteriograms showed a lesion in the left parietotemporal area; at operation a well-circumscribed, gray-black mass, 5 cm. in diameter, was totally removed from this site. Histologically the lesion was metastatic melanoma.

The patient remained well until 1959 when an anemia was noted on a routine follow-up visit. An upper gastrointestinal series showed a lesion involving the jejunum. At operation a tumor was completely surrounding a 4 cm. segment of bowel. The mass had eroded the mucosa and extended into the mesentery. All gross tumor was removed by jejunal resection. Histologic examination again showed the tumor to be metastatic melanoma. The lymph nodes in the excised mesentery did not contain neoplasm.

At that time a chest roentgenogram showed a 1 cm. nodule in the lower lobe of the right lung that had not been evident on previous examinations. No further treatment was given, however, and no symptoms developed over the next few years. In 1963 this lesion increased to a size of 3 cm. in a period of several months. It was removed by a superior segmentectomy of the right lower lobe. Again, the diagnosis was metastatic melanoma. At present the patient is well; there are no symptoms or signs of recurrent tumor. The chest X-ray is negative.

Also of interest in the patient's history is that she had a radical mastectomy for adenocarcinoma of the left breast in 1946 and a wedge excision of the ileum in 1949 for a carcinoid tumor which had caused an intussusception.

Comment: In this case, the tumor metastasized successively to regional lymph nodes, brain, small bowel, and lung. Progression of the disease was relatively slow — the lung metastasis, for example, was under observation for 4 years before it began to enlarge. It has been 28 years since the original lesion was treated with radium, 20 years since her first recurrence, and 7 years since the last recurrent lesion was removed. The occurrence of

---

Doctor Foley is an Instructor in Surgery and Doctor Coon is a Professor of Surgery at the University of Michigan Medical School. From the Department of Surgery, Section of General Surgery, University of Michigan Medical Center, Ann Arbor, Michigan.

melanoma and two other types of tumor in this patient raises questions of host susceptibility; at the same time the remarkably slow progression of the malignant melanoma and the apparent effectiveness of surgical control of all three of these tumors leads to interesting speculation about host resistance. The patient as a host seems to be both "susceptible" and "resistant."

Case 2

In December 1957, a 38-year-old woman consulted her physician about recent changes in a mole on her left leg. The mole had been present for at least 10 years but had recently enlarged and ulcerated and was bleeding. The lesion, which was located over the tibial tubercle, was excised. A diagnosis of malignant melanoma was made. Wide local excision with skin grafting was carried out along with ilioinguinal lymph node dissection. No tumor cells were found in the excised tissue and nodes.

In February 1959, the patient returned stating that black spots had developed on her left thigh. On examination, there were over 100 pigmented nodules, the largest measuring up to 1 cm. in diameter, which were in the line of lymph flow from the site of the earlier lesion to the inguinal ligament. Biopsy of one of these skin nodules confirmed the presence of recurrent metastatic melanoma. No other metastases beyond the thigh were noted on examination. Exploratory laparotomy to rule out liver metastasis was planned, to be followed by hip disarticulation. The patient refused operation and was discharged from the hospital without further treatment. At her return visit a month later the nodules were found to be regressing, and within 5 months all had disappeared except 6 flat "freckles" on the anterior thigh.

Five years later in March 1964, the patient had a hysterectomy performed for fibroid tumors of the uterus. No recurrence of the malignant melanoma was noted on clinical examination, and no metastases were seen in the liver or other abdominal viscera at operation. Three months after the hysterectomy, the patient returned because of a swelling in her left thigh that had been present for about 4 weeks. A nodule had also developed in the subcutaneous tissue overlying the left scapula; on histologic examination the lesion was metastatic melanoma. The mass in the left thigh measured 10 x 7 cm. and caused the patient considerable discomfort. A course of radiation therapy to this area resulted in some shrinkage of the mass and alleviation of pain. During the next 3 months, widespread metastases developed. Systemic chemotherapy was ineffective and the patient died in November 1964.

At necropsy, metastatic melanoma was found in the brain, liver, lungs, adrenal glands, breast, thyroid, intestine, stomach, subcutaneous tissue, and the axillary, retroperitoneal and peripancreatic lymph nodes.

Comment: This case was marked by a spontaneous regression of proven metastatic melanoma of the thigh which persisted for over 5 years. Then, shortly after hysterectomy, widespread metastases developed in a few months, leading to death.

Case 3

A 62-year-old white man had an ulcerated pigmented mole removed from his right thigh in March 1950. A diagnosis of malignant melanoma was made. Nine months later nodes were palpable in the right groin; these were excised. The lymph nodes contained metastatic malignant melanoma. Three months later a mass recurred in this area and was treated with radiation therapy.

In November 1951, the patient entered the University of Michigan Medical Center for treatment of an ulcerated mass measuring 16 x 8 x 5 cm. in the right groin. There were many small pigmented satellite nodules in the surrounding skin and a 5 x 5 cm. mass in the left groin. A chest roentgenogram showed 5 pulmonary lesions in the lungs. These lesions had not been evident 2 months before, and therefore were presumed to be metastases.

A portion of the right groin mass was excised and the diagnosis of metastatic malignant melanoma reconfirmed. The remaining excised tumor was injected into rabbits in an attempt to develop "tumor antibodies" which would then be labeled with I_{131} as an experiment in a study which was in progress here at that time. Accordingly, 27 millicuries of "tagged antibodies" were given to the patient on December 11, 1951, and this dose was repeated on January 4, 1952. Three weeks later the chest roentgenogram showed that all but one of the presumed metastatic lesions in lung were no longer evident, and the mass in the right groin was about half its previous size. Another injection of radioactive material was given. A chest roentgenogram taken in March 1952 showed complete disappearance of the pulmonary parenchymal lesions. By May of that year the tumor in both groins was no longer apparent and the only signs of disease were a few pigmented spots in the right inguinal area.

In February 1954, a 5 cm. mass recurred in the right groin and was excised. The histological diagnosis was again metastatic melanoma. Following this, the patient had no further evidence of neoplastic disease. He died in February 1958 from coronary artery disease. No neoplasm was found at necropsy.

Comment: Subsequent attempts to repeat the experience with "tagged antibodies" in other cases were not successful. This case might represent either an isolated individual response to such therapy, or more likely, a spontaneous regression of malignant melanoma with the subsequent groin recurrence being adequately treated by excision. The patient died of an unrelated cause about 7 years after proven recurrence of malignant melanoma, and no tumor was found at necropsy.

Discussion

As demonstrated by Case 1, when the primary lesion of malignant melanoma has been effectively controlled, excision of isolated metastatic lesions that develop may be worthwhile in selected cases. The longer the interval in which the primary tumor has been controlled, the greater the likelihood for achieving success with operation for metastatic lesions which can be totally removed. Mundth and his co-workers[1] reported a 5 year survival rate of 8% among patients following treatment of local or metastatic recurrences that appeared within one year after the initial treatment of the primary melanoma. If the recurrence developed more than 2 years after initial treatment, the 5 year survival rate was 41% when the recurrent tumor was treated aggressively.

On the whole, spontaneous regression of malignant tumors is rare. Everson and Cole[2] in their 1965 monograph, were able to find only 176 cases that could be adequately documented. Over half of these represented 4 types of cancer: hypernephroma, neuroblastoma, malignant melanoma, and choriocarcinoma. Nineteen cases of spontaneous regression of malignant melanoma were cited.

The true incidence of spontaneous regression of malignant melanoma is difficult to determine since malignant melanoma is sometimes found in lymph nodes in cases in which a primary site is not apparent. The possibility exists that the site of origin remains hidden rather than that the original tumor regressed. In almost 9% of 461 patients with malignant melanoma reported by Smith and Stehlin,[3] metastases in lymph nodes were found without the primary tumor being located. They were able to document only 9 cases with clear evidence of regression of a primary tumor. McNeer and Das Gupta[4] pointed out that in their experience, spontaneous regression of tumor was always followed by recurrence at a later time, as was demonstrated in Case 2 reported here. Although our third case showed no recurrence within 7 years, and no tumor was found at necropsy, recurrence might still have developed if the patient had lived longer.

In Case 2, recurrence of tumor with rapid widespread dissemination developed shortly after an unrelated operation. This relationship may be coincidental, but it has been noted by others.[5] It is interesting to speculate whether perhaps the operation may be a factor in the recurrence by precipitating a loss of host control of the tumor.

The mechanisms causing spontaneous regression of malignant melanoma are not known, but endocrine and immunologic bases may offer possible explanations. The impetus for speculation about an endocrine basis comes from five separate and apparently unrelated observations: (1) other types of tumor, particularly in the breast, thyroid and prostate, do respond to endocrine manipulation; (2) in only rare instances are melanomas occurring before puberty malignant; (3) the adrenal-pituitary axis controls melanin production; (4) the survival rate for malignant melanoma is higher for women than for men,[6] and (5) several isolated cases of spontaneous regression of malignant melanoma associated with pregnancy have been reported.[5, 7, 8, 9] In general, however, the clinical course of malignant melanoma in pregnant women is similar to that in nonpregnant women.[10] Hypophysectomy, orchiectomy, adrenalectomy, androgen and estrogen therapy have been tried in this disease without significant success.[11-15]

Melanin is a product of the tyrosine cycle. There is however, no evidence to support a hypothesis than an alteration in the metabolism of melanin could be the basis for spontaneous regression of this tumor. It appears that the melanocyte itself is malignant and that the melanin the cells contain is not essential to the malignant process. At least amelanotic melanomas occur, and melanin from destroyed malignant melanoma cells, when picked up by phagocytes in lymph nodes and in the surrounding tissue, is not capable of producing malignant changes in these phagocytes. Nevertheless, one of the palliative chemotherapeutic approaches to malignant melanoma has been the use of phenylalanine mustard in an effort to introduce a toxic agent into the tyrosine cycle of melanin production and thus control the overactive malignant cells.

An immunologic basis for spontaneous regression is suggested by reports of cases which apparently responded to transfusion of blood from other patients with spontaneous regression.[2, 5, 16, 17] These cases, however, have been isolated instances which were not duplicated with further study. Blood from Case 1 reported here was given to another patient without effect.

Although new approaches to the treatment of cancer are essential Case 3 again points out the importance of careful studies in a series of patients before valid conclusions can be made about a new form of therapy. In a controlled series the use of radioactive "antibodies" proved to be without value.[18] It appears likely that the initial patient in whom this therapy was tried had a coincidental spontaneous regression of tumor.

Why spontaneous regression of malignant

melanoma occurs, remains an enigma. So far, no constant feature has been identified. The problem is extremely complicated because of the great numbers of "unknowns" in both host response and tumor pathogenesis and because of the very small number of cases which become available for analysis. Continuing study of this phenomenon is vital, however, since it may be a key to the solution of control of this and other malignant processes.

Summary

Three patients with malignant melanoma are reported in whom unusual clinical courses ensued. One patient demonstrates the value in selected cases of excising recurrent isolated metastases from malignant melanoma when the primary is adequately controlled. Two patients with spontaneous regressions of malignant melanomas are reported. Some speculations about the etiology of spontaneous regression of malignant melanoma are discussed.

References

1. Mundth, E. D., Guralnick, E. A., and Raker, J. W.: Malignant Melanoma: A Clinical Study of 427 Cases, Ann Surg, 162:15-28, 1965.
2. Everson, T. C., and Cole, W. H.: *Spontaneous Regression of Cancer,* Philadelphia: W. B. Saunders Co., 1966, Chapter 4, pages 164-220.
3. Smith, J. L., and Stehlin, J. S.: Spontaneous Regression of Primary Malignant Melanomas with Regional Metastases. Cancer, 18:1399-1415, 1965.
4. McNeer, G., and Das Gupta, T.: Prognosis in Malignant Melanoma, Surg, 56:512-518, 1964.
5. Boyd, W.: *The Spontaneous Regression of Cancer,* Springfield, Ill.: Charles C. Thomas, 1966, page 15-24.
6. White, L. P.: Studies on Melanoma, II Sex and Survival in Human Melanoma, New Eng J Med 260:789-797, 1959.
7. Sumner, W. C.: Spontaneous Regression of Melanoma; Report of a Case. Cancer 6:1040-1043, 1953.
8. Allen, E. P.: Malignant Melanoma, Spontaneous Regression after Pregnancy, Brit M J, 2:1067, 1955.
9. Everson, T. C.: Spontaneous Regression of Cancer, Ann N Y Acad Sci, 114:721-735, 1964.
10. George, P. A., Fortner, J. G., and Pack, G. T.: Melanoma with Pregnancy, A Report of 115 Cases, Cancer, 13:854-859, 1960.
11. Cade, S.: Malignant Melanoma, Brit M J, 1:119-124, 1957.
12. Shimkin, M. B., Boldrey, E. B., Kelley, K. H., Bierman, H. R., Ortega, P. and Naffziger, H. C.: Effects of Surgical Hypophysectomy in Man with Malignant Melanoma, J Clin Endocrin, 12:439-453, 1952.
13. Herbst, W. P.: Malignant Melanoma of Choroid with Extensive Metastasis Treated by Removing Secreting Tissue of Testicles. J.A.M.A., 122:597, 1943.
14. Howes, W. E.: Castration for Advanced Malignant Growth: Short Historical Review with a Case Report. Radiology, 43:272-274, 1944.
15. Huggins, C., and Bergenstal, D. M.: Inhibition of Human Mammary and Prostatic Cancers by Adrenalectomy, Cancer Res, 12:134-141, 1952.
16. Sumner, W. C., and Foraker, A. O.: Spontaneous Regression of Human Melanoma, Clinical and Experimental Studies, Cancer, 13:79-81, 1960.
17. Teimourian, B., and McClure, W. S.: Surgical Managment of Malignant Melanoma, Am Surg, 29:515-519, 1963.
18. Vial, A. B. and Callahan, W.: The Effect of Some Tagged Antibodies on Human Melanoblastoma, Cancer, 10:999-1003, 1957.

A Controlled Study of Of Niacinamide Therapy

By George R. Thompson, M.D.
Ann Arbor
Ivan F. Duff, M.D.
Ann Arbor
Eigill F. Hvidberg, M.D.
Copenhagen
Jack C. Barthwell, R.Ph.
Eloise

Several reports in the medical literature[1, 2, 3] indicated that large doses of niacinamide (3.0 to 4.0 grams daily) were beneficial in treating arthritis. However, they did not clearly define the type of arthritis studied, and comparisons with control subjects were not made.

These reports, however, stimulated considerable interest among both laymen and physicians. Physicians were asked by their rheumatoid arthritis patients the value of niacinamide therapy and often were requested to prescribe the drug. Thus it was decided to undertake a controlled, double-blind study of niacinamide in rheumatoid arthritis.

A theoretical explanation for the presumed value of niacinamide had not been offered. However, it is known that in vivo, niacinamide is converted to the coenzyme niacinamide-adenine-dinucleotide (NAD). Further, the reduced form (NADH) is often used as a reducing agent in biological reactions. Thus we postulated that possibly niacinamide functioned as penicillamine[4] reducing disulfide bonds, and hence possibly decreasing the titer of rheumatoid factor. This theoretical possibility lent further impetus to undertake a therapeutic study of niacinamide in rheumatoid arthritis.

Doctor Thompson, Doctor Duff and Mr. Barthwell are with the Department of Medicine, Wayne County General Hospital, Eloise, the Department of Internal Medicine and the Rackham Arthritis Research Unit, The University of Michigan. Doctor Hvidberg is now at the University of Copenhagen, Denmark. Their study was supported by a grant from the Michigan chapter, the Arthritis Foundation.

Materials and Methods

Only patients with either classical or definite rheumatoid arthritis, as defined by American Rheumatism Association criteria,[5] were admitted to the study. All patients had disease of at least one year's duration, and onset after their sixteenth birthday. Patients on gold therapy were admitted to the study if they had received over 1,000 mg, and were on a stable, maintenance dose. Antimalarial drugs, phenylbutazone, oxphenbutazone, indomethacin and systemic adrenocorticosteroids were not allowed, and must have been stopped a minimum of six weeks prior to the study. Aspirin was allowed ad lib, as were analgesics.

Niacinamide in 500 mg. tablets was obtained from an independent pharmaceutical house, (Bell-Craig Pharmaceuticals, Inc., Long Island City, New York), which also supplied a similar appearing placebo. The study drug (niacinamide or placebo) was packaged by the hospital pharmacy in coded bottles, the code being kept by the hospital pharmacist and was not broken until after completion of the study.

The design of the study was cross-over, double-blind. Each patient received both niacinamide and the placebo, and served as his own control. The treatment period for niacinamide and placebo was 12 weeks each. This allowed adequate time for the drug to exert its effect, and also reduced erroneous conclusions resulting from daily changes due to variations in disease activity. The patients were seen at two-week intervals, and at each visit a data sheet was completed, including complete joint evaluation, measurement of grip strength, walking time, and blood and urine examinations.

A total of 13 patients were admitted to the study. However, it was necessary to drop six of these patients for a variety of reasons (see next page). Seven patients were carried through to completion of the study and constitute the basis of this report. All had active rheumatoid arthritis as manifested by elevated erythrocyte sedimentation rate and clinically active synovitis. None were stage four patients with ankylosed joints. Two were male and five female. The age range was from 27 to 78 years.

		Niacinamide			Placebo		
Patient	**Base Line**	**4 wks.**	**8 wks.**	**12 wks.**	**4 wks.**	**8 wks.**	**12 wks.**
J. Sm.	1 hr.	2½ hr.	3 hr.	5+ hr.	6+ hr.	4½ hr.	4½ hr.
W. F.	½	½	½	5+	5+	5+	½
M. P.	2	4	3½	2½	6	5½	5
M. C.	0	0	0	1/12	0	1/12	1/6
E. C.	½	½	1/6	0	0	0	0
J. Su.	½	½	½	1	1	1	½
C. D.*	1	1	2	1	½	½	1½

---

*Received Placebo First

Table 1: Average Duration of Morning Stiffness Expressed in Hours while on Niacinamide and on the Placebo

Results

The data was analyzed from the standpoint of clinical parameters and laboratory studies. The clinical data was further subdivided into subjective criteria (i.e., hours of morning stiffness; functional capacity); and objective criteria (i.e., walking time; grip strength). The joint index was calculated on the basis of tenderness or pain on motion, swelling, and heat in each joint as determined by the investigator. These were scored on a basis of + if definite; ± if in doubt, or 0. A numerical score of 2 was given for + and 1 for ±. The total score was then summated for each visit and this was termed the joint index. Six of the patients received niacinamide first, and one placebo. Excellent agreement was found between all parameters studied.

Tables 1 and 2 list the number of hours of morning stiffness and joint index while on niacinamide and placebo. Morning stiffness remained essentially unchanged, or worsened, while on niacinamide, as did the joint index. The grip strength (measured in millimeters of mercury) was unchanged or worsened in four and improved in two. However, this improvement continued while on placebo. Regarding functional capacity and subjective assessment, four patients were no better or worsened. One patient improved, but continued improving while on the placebo. Patient M.P. felt she was better while on niacinamide, but this improvement was not substantiated by the joint index or laboratory studies.

Thus it was concluded that from the clinical assessment of these patients there was no evidence that niacinamide was of benefit.

Table 3 lists the Westergren erythrocyte sedimentation rate. Only in patient J. Su. was there improvement, and in this patient improvement continued while on placebo. The C-reactive protein paralleled the sedimentation rate. In no patient was there a fall in titer of rheumatoid factor (latex tube test). Serum protein electrophoretic pattern was unchanged, as were tests designed to indicate toxicity of the drug (bilirubin, serum glutamic oxaloacetic transaminase, lactic dehydrogenase, alkaline phosphatase, blood urea nitrogen, white blood cell count and urinalysis).

Six patients were started on the study but subsequently dropped. Two were stopped because of possible toxicity to the drug. One patient (L.S.) developed gastrointestinal upset and headaches, and was stopped. Another patient (M.D.) developed a skin rash, similar to the rash she had previously experienced while on gold therapy. This could have represented a recrudescence of her gold dermatitis. Patient L.B. was involved in an automobile accident. Patient C.R., on the placebo, developed many bizarre symptoms, all felt to be on a psychogenic basis, and was dropped. Patient S.K., on visit 1 of the study (on placebo) was found to be pregnant. Patient B.U., while on the placebo, developed a change in the nature of her disease indicative of lupus erythematosus, and subsequently was stopped after visit 2 on niacinamide. This lady for many years had had disease meeting the A.R.A. criteria for classical rheuma-

		Niacinamide			Placebo		
Patient	**Base Line**	**4 wks.**	**8 wks.**	**12 wks.**	**4 wks.**	**8 wks.**	**12 wks.**
J. Sm.	122	112	110	172	186	170	172
W. F.	68	20	48	142	144	150	118
M. P.	132	169	144	157	180	164	172
M. C.	80	86	62	88	84	86	74
E. C.	93	22	39	30	36	35	32
J. Su.	163	145	145	162	162	146	118
C. D.*	22	54	76	78	40	46	64

*Received Placebo First

Table 2: Joint index determined while on Niacinamide and placebo. The joint index is derived by examining each joint for tenderness, swelling, or heat; assigning the numerical value of 2 for each parameter if present, 1 if doubtful; then summing all of the numbers. Thus, the more active the arthritis, the higher the joint index.

		Niacinamide			Placebo		
Patient	**Base Line**	**4 wks.**	**8 wks.**	**12 wks.**	**4 wks.**	**8 wks.**	**12 wks.**
J. Sm.	38 mm.	36 mm.	22 mm.	48 mm.	38 mm.	32 mm.	40 mm.
W. F.	42	52	50	65	60	69	61
M. P.	22	26	23	22	23	25	19
M. C.	21	20	20	29	35	36	45
E. C.	10	12	29	32	16	13	13
J. Su.	80	53	29	36	26	16	24
C. D.*	24	30	41	34	32	25	30

*Received Placebo First

Table 3: Westergren Sedimentation Rate (in millimeters per hour) while on niacinamide and the placebo.

toid arthritis, but had persistently positive L.E. cell tests.

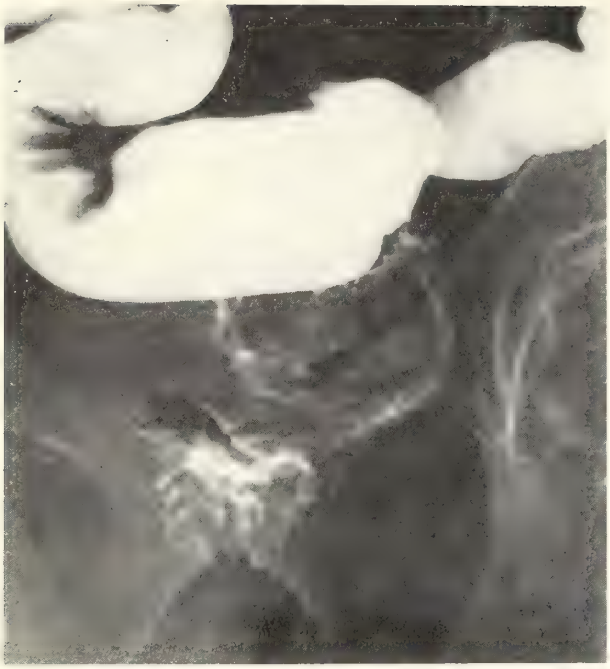
Conclusions

It is concluded from the data presented that this study indicates no benefit of niacinamide therapy in rheumatoid arthritis. It is unfortunate that six of the original 13 patients started on the study were subsequently lost. As a result six of the seven patients carried to completion received niacinamide first. This produced a bias in favor of the drug, as the first medication received has the psychological advantage of being a "new treatment." However, despite this unintentionally favorable position niacinamide received in the study, no benefit was observed. This is felt to further substantiate our conclusions derived from the data above, that niacinamide is without value in rheumatoid arthritis. In the doses used (3.0 grams per day), however, the drug was well tolerated.

Please send reprint requests to Doctor Thompson at Wayne County General Hospital, Eloise, 48132.

References

1. Hoffer, A.: "Treatment of arthritis by nicotinic acid and nicotinamide." *The Canadian Medical Association Journal.* 81: 235-238, August 15, 1959.
2. Kaufman, Wm.: "The use of vitamin therapy to reverse certain concomitants of aging." *J. Amer. Geriatrics Society.* 3: 927-936, November 1955.
3. Kaufman, Wm.: "Niacinamide therapy for joint mobility." *Connecticut State Medical Journal.* 17: 584-589, 1953.
4. Lorber, Arthur: "Penicillamine therapy for rheumatoid lung disease: effects on protein sulphydryl groups." *Nature.* 210: 1235-1237, June 18, 1966.
5. Ropes, N. W.; Bennett, G. A.; Cobb, S.; Jacox, R.; and Jessar, R. A.: 1958 revision of diagnostic criteria for rheumatoid arthritis. *Bull. of Rheumat. Dis.* 9: 175-176, December 1958.



The Viewbox

By Raymond S. Kurtzman, M.D.
MSMS Associate Scientific Editor

Diagnosis

VILLOUS ADENOMA OF THE RECTUM.

X-Ray Findings

There is a mass in the rectum, as outlined on barium enema, measuring about 5cm. in diameter. Note the delicate linear collections of barium on the surface of the tumor, which represent accumulations of contrast material in the fine folds of the villous adenoma. These delicate folds on a bulky tumor strongly suggest the diagnosis, although occasionally, villous tumors can be nodular.

Discussion

Villous adenoma is a tumor of epithelial origin which occurs most commonly in the rectum and the colon in general, and less often in the small bowel and stomach. A syndrome consisting of hypoproteinemia and electrolyte loss, due to "weeping" of these materials from the surface of the tumor, occurs at times with villous adenoma, but is relatively infrequent. This patient, for example, did not have the syndrome, but did have rectal bleeding, probably the commonest major symptom. These tumors are soft and therefore can be missed on digital rectal examination. Occasionally these tumors are multiple. Adenomatous polyps of this size are almost always malignant, but only half of similar villous adenomas are malignant. Because of their size, multiple sections of the tumor are required to exclude malignancy, when they are removed surgically.

Bibliography

Ramirez, R. F., Culp, C. E., Jackman, R. J., and Dockerty, M. B.: "Villous tumors of the lower part of the large bowel," J.A.M.A. 194:863, 1965.

Wolf, B. S.: Roentgen diagnosis of villous tumors of the colon, Amer. J. Roentgen 84:1093, 1960.

Michigan Authors

Manuel Sklar, M.D., F.A.C.G., Detroit, "Functional Gastrointestinal Disease in the Aged," page 570, *The American Journal of Gastroenterology,* June, 1970.

Newell A. Augur, Jr., M.D., and William A. Gracie, Jr., M.D., Ann Arbor, "Cholecystocolonic Fistula Associated with Malabsorption," page 558, *The American Journal of Gastroenterology,* June, 1970.

Hilliard Jason, M.D., Ed.D., East Lansing, "Relevance of Medical Education to Practice," page 2092, *Journal of the American Medical Association,* June 22, 1970.

R. H. Stewart, M.D., and S. B. Webster, M.D., Detroit, "Cross Reactivity: Ampicillin and Penicillin G," page 131, *Journal of the American Medical Association,* July 6, 1970.

Thomas J. DeKornfeld, M.D., Ann Arbor, "Medical Advisor's Column," page 7, *The Michigan Airway,* Quarterly Journal of the Michigan Society for Inhalation Therapy, June, 1970.

F. A. Baughman, Jr., M.D., Grand Rapids, and E. J. Randinitis, Ph.D., Detroit, "Placental Passage of Diphenylhydantoin," page 466, *Journal of the American Medical Association,* July 20, 1970.

New Drug Information

To provide helpful and unbiased information for physicians about new drug products, the authors of the regular MICHIGAN MEDICINE feature, "Drugs and Therapy Problems," have prepared the following article. Their work is supported in part by a grant from the Michigan Association for Regional Medical Programs (MARMP), but it does not necessarily represent the views of MARMP or the Department of HEW.

Doxepin HCl (Sinequan®) — Current Information

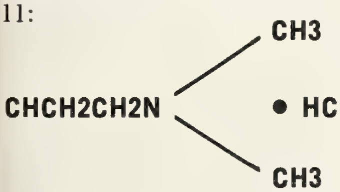
By Fred J. Salter, Pharm. D.
Robert E. Pearson, M.S.
Ann Arbor

Description

First of a new chemical series known as dibenzoxepin derivatives, doxepin is reputed to possess anti-anxiety and antidepressant activity. Doxepin has prominent anticholinergic activity, but its precise mechanism of action is unknown.

Chemistry

Doxepin HCl is N,N-Dimethyl-dibenz (b,e) oxepin-$\Delta^{11(6H)}$, γ propylamine hydrochloride. It is quite similar to the tricyclic derivatives chemically and pharmacologically. Doxepin differs from amitriptyline only by having an oxygen in place of a CH_2 group in the 7 membered meso ring at position 11:



$CHCH_2CH_2N(CH_3)_2 \cdot HCl$

Doxepin is a stable, white crystalline solid, soluble in water, lower alcohols, and chloroform and sensitive to light. Stability studies at 25 degrees and 37 degrees C show doxepin to be stable requiring no expiration date.[1]

Metabolism and Excretion

Doxepin is well absorbed after oral administration. Animal studies indicate numerous metabolites of doxepin are found in the liver and urine. Metabolic transformation (by the liver and kidneys) include demethylation, N-oxidation, hydroxylation, and glucuronide formation. Doxepin is excreted primarily in the urine, but also in the feces.[1]

Doxepin crosses the blood-brain barrier and probably the placental barrier. It is not known if it passes into the milk of nursing mothers.[1]

Therapeutic Use and Efficacy

The manufacturer recommends doxepin for treatment of numerous states of anxiety, depression, or in mixed states. It is said to have "marked" anti-anxiety and "significant" antidepressant activity.[1]

Despite claims for the biphasic activity of doxepin,[1,2] most studies to date have involved patients with depressive or mixed anxiety-depressive diseases.[3-13]

Double-blind studies with amitriptyline indicate doxepin to be at least as effective as the former drug in patients with depression.[2,3,4,7]

It is not apparent that doxepin has significant anti-anxiety activity in conditions other than when anxiety is secondary to depression. Since amitriptyline also is effective in such conditions, additional studies are necessary to clearly demonstrate the clinical advantages of doxepin over amitriptyline.

Dosage and Route of Administration

A usual starting dosage is 25 mg. 3 times daily with an optimum range of 75-150 mg. per day. The maximum recommended dosage of doxepin is 300 mg. per day. Additional therapeutic benefit is seldom seen above this level.[1]

The oral route is the only presently available method of administration.

Note

As with amitriptyline, optimal antidepressant response may not be apparent for 2-3 weeks. It is stated that anti-anxiety activity is rapidly apparent.[1]

Mr. Salter is associate project coordinator and Mr. Pearson is project coordinator for the Michigan Regional Drug Information Center, University Hospital, Pharmacy Department, Ann Arbor.

Contraindications

Hypersensitivity; glaucoma; tendency for urinary retention; concomitant administration with MAO inhibitors; pregnancy (unless otherwise deemed necessary in the judgement of the physician); or the use in children under 12 years old constitute contraindications to doxepin.[1]

$X = CH_2$ (Amitriptyline)
$X = O$ (Doxepin)

Adverse Reactions

Doxepin primarily causes anticholinergic side effects such as dry mouth, blurred vision, and constipation.[1] Drowsiness may occur early in treatment, later tending to disappear.[1]

Infrequently reported side effects include tachycardia, [2,14] extrapyramidal symptoms, nausea, increased sweating, weakness, dizziness, fatigue, weight gain, edema, paresthesia, flushing, chills, tinnitus, photophobia, decreased libido, rash, and pruritus.[1] Insomia, excitement, restless agitation, depression, toxic confusional states, headache, and symptomatic hypotension have also been reported.[2] The manufacturer states no liver disorders, blood dyscrasias, lens opacities, or pigment disorders have been reported to date.[1]

Doxepin has not been reported to produce dependence.[1] It does not antagonize the hypotensive effect of guanethidine in dosages of 75-150 mg. per day. Dosages exceeding 300 mg. per day will cause a significant blocking effect.[15]

Teratogenic Potential

Doxepin has not been found to be teratogenic in animals. Its effect on humans is unknown.[1]

Toxicity

Data is not available for man, but the acute LD 50 in mice is 125 mg./Kg.[1] Toxic symptoms are referrable to CNS depression: ataxia, respiratory depression, convulsions, occasionally peripheral vasodilation or constriction, prostration and death.[1]

Supply

Pfizer Laboratories
10 mg. red and pink capsules
25 mg. pink and blue capsules
50 mg. pink and beige capsules

References

1. Pfizer Laboratories Product Information, Sinequan, (September) 1969.
2. Pitts, Norman E. "The Clinical Evaluation Doxepin — A New Psychotherapeutic Agent" *Psychosomatics* 10: 164-171 (May-June) 1969.
3. Bergener, M. "Klinische Prufung Antidepressiv Wirksamer Substanzen in Doppelblindversuch" *Arzneimittelforschung* 18: 245-249 (Feb.) 1968 Per deHaen Drugs In Use Abstract.
4. Gomez-Martinez, I. "Preliminary Double-Blind Clinical Trial with a New Antidepressive Doxepin" *Curr. Ther. Res.* 10: 116-118 (March) 1968.
5. Gallant, D. M. et al "Doxepin Versus Diazepam: A Controlled Evaluation in 100 Chronic Alcoholic Patients" *J. Clin. Pharm.* 9: 57-65 (Jan.-Feb.) 1969.
6. Johnston, E. E. and Claghorn, J. C. "Doxepin vs. Chlordiazepoxide: A Controlled Comparison in Neurotic Outpatients" *Curr. Ther. Res.* 10: 514-519 (Oct.) 1968.
7. Hackett, E. et al "Controlled Evaluation of Psychotropic Drugs in A Private Psychiatric Practice. Doxepin vs. Amitriptyline" *Psychosomatics* 8: 162-165 (May-June) 1967.
8. Belsasso, G. et al "Clinical Investigation with Doxepin, A New Antidepressant" *Curr. Ther. Res.* 11: 165-168 (April) 1969.
9. Boysen, K. H. "Behandlung Depressiver Zustandbilder mit Doxepin" *Wien Med. Wschr.* 118: 1095-1099 (Dec. 21) 1968 Per deHaen Drugs In Use Abstract.
10. Goldstein, B. J. and Pinosky, D. G. "Clinical Evaluation of Doxepin in Anxious Depressed Outpatients" *Curr. Ther. Res.* 11: 169-177 (April) 1969.
11. Krakowski, A. J. "Activity of Doxepin. A New Antidepressant" *Psychosomatics* 9: 89-95 (Mar.-Apr.) 1968.
12. Poldinger, W. "Vergleichende Klinische Erfahungen mit neuen trizyklischen Psychopharmaka" *Ther. Umsch.* 23: 373-375 (Sept.) 1966 Per deHaen Drugs In Use Abstract.
13. Bergener, M. and Behrends, K. "Zur Klinischen Prufung von Doxepin, einer neuartigen Antidepressiv Wirksamen Sutstanz" *Arzneimittelforschung* 16: 1617-1620 (Dec.) 1966 Per deHaen Drugs In Use Abstract.
14. Ayd, F. J. "A Clinical Evaluation of Doxepin (Sinequan) — A New Psychotherapeutic Agent" *Dis. Nerv. Syst.* 30: 396-401 (June) 1969.
15. Oates, John A. et al "Effect of Doxepin on the Norepinephrine Pump — A Preliminary Report" *Psychosomatics Supplement* 10: 12-13 (May-June) 1969.

Campbell's Soups... wide variety...for limited appetites

Many people lose interest in food as they grow older. Some of them are fussy eaters—with only a few favorite foods. Others become indifferent to foods—because planning and preparing meals becomes a chore. Here Campbell's Soups can help —for these four very good reasons:

Appeal With a variety of tastes, textures, aromas, and colors, Campbell's Soups can add interest and appetite appeal. And they're easy to eat—ingredients are tender, bite-size. Even patients on special diets will find soups they can enjoy among the more than 50 different varieties available.

Campbell's
SOUP

Nourishment Campbell's Soups contain selected meats and sea foods, best garden vegetables—carefully processed to help retain their natural flavors and nutritive values.

Convenience Within 4 minutes a bowl of delicious soup is heated and ready to eat.

Economy Campbell's Soups are inexpensive—an important consideration to those whose budgets are limited.

Recommend Campbell's Soups . . . and, of course, enjoy them yourself. Remember, *there's a soup for almost every patient and diet . . . and for every meal.*

digitalis-diuretic
regimens can put a
"potassium squeeze"
on the myocardium...

therefore this is the logical potassium-sparing diuretic for the digitalized patient

Aldactone®

(spironolactone)

for unique physiologic advantages which no other diuretic can provide

- Does not cause potassium depletion (as do the thiazides, furosemide and ethacrynic acid) which may increase[1] the effect of digitalis on the myocardium, giving rise to premature systoles, ventricular tachycardia or ventricular fibrillation.
- Unique "safety-valve" action due to competitive antagonism[2] of aldosterone helps prevent excessive potassium retention, since endogenous aldosterone production is increased[3] and counterbalances Aldactone action if the serum potassium level becomes too high.
- Hyperkalemia may occur, especially in severely ill patients with relatively small urine outputs or in patients receiving supplemental potassium. However, with Aldactone, because of its mechanism of action, hyperkalemia[3] should be less likely than with triamterene or other agents which act independently of aldosterone.
- Gradual onset of action avoids the danger[4] of sudden electrolyte and fluid depletion.
- May be effective as the sole diuretic or may be combined with a thiazide, furosemide[5] or ethacrynic acid[6].

Indications—Essential hypertension; edema or ascites of congestive heart failure, cirrhosis of the liver and the nephrotic syndrome; idiopathic edema. Some patients with malignant effusions may benefit from Aldactone, particularly when given with a thiazide diuretic.

Contraindications—Acute renal insufficiency, rapidly progressing impairment of renal function, anuria and hyperkalemia.

Warnings—Potassium supplementation may cause hyperkalemia and is not indicated unless a glucocorticoid is also given. Discontinue potassium supplementation if hyperkalemia develops.

Usage of any drug in women of childbearing age requires that the potential benefits of the drug be weighed against its possible hazards to the mother and fetus.

Precautions—Patients should be checked carefully since electrolyte imbalance may occur. Although usually insignificant, hyperkalemia may be serious when renal impairment exists; deaths have occurred. Hyponatremia, manifested by dryness of the mouth, thirst, lethargy and drowsiness, together with a low serum sodium may be caused or aggravated, especially when Aldactone is combined with other diuretics. Elevation of BUN may occur, especially when pretreatment hyperazotemia exists. Mild acidosis may occur. Reduce the dosage of other antihypertensive drugs, particularly the ganglionic blocking agents, by at least 50 per cent when adding Aldactone since it may potentiate their action.

Adverse Reactions—Drowsiness, lethargy, headache, diarrhea and other gastrointestinal symptoms, maculopapular or erythematous cutaneous eruptions, urticaria, mental confusion, drug fever, ataxia, gynecomastia, mild androgenic effects, including hirsutism, irregular menses and deepening voice. Adverse reactions are infrequent and usually reversible.

Dosage and Administration—For *essential hypertension* in *adults* the daily dosage is 50 to 100 mg. in divided doses. Aldactone may be combined with a thiazide diuretic if necessary. Continue treatment for two weeks or longer since an adequate response may not occur sooner. Adjust subsequent dosage according to response of patient.

For *edema, ascites* or *effusions* in *adults* initial daily dosage is 100 mg. in divided doses. Continue medication for at least five days to determine diuretic response; add a thiazide or organic mercurial if adequate diuretic response has not occurred. Aldactone dosage should not be changed when other therapy is added. A daily dosage of Aldactone considerably greater than 75 mg. may be given if necessary.

A glucocorticoid, such as 15 to 20 mg. of prednisone daily, may be desirable for patients with extremely resistant edema which does not respond adequately to Aldactone and a conventional diuretic. Observe the usual precautions applicable to glucocorticoid therapy; supplemental potassium will usually be necessary. Such patients frequently have an associated hyponatremia—restriction of fluid intake to 1 liter per day or administration of mannitol or urea may be necessary (these measures are contraindicated in patients with uremia or severely impaired renal function). Mannitol is contraindicated in patients with congestive heart failure, and urea is contraindicated with a history or signs of hepatic coma unless the patient is receiving antibiotics orally to "sterilize" the gastrointestinal tract.

Glucocorticoids should probably be given first to patients with nephrosis since Aldactone, although useful for diuresis, will not directly affect the basic pathologic process.

For *children* the daily dosage should provide 1.5 mg. of Aldactone per pound of body weight.

References: 1. Dall, J. L. C.: Amer. Heart J. *70*:572-574 (Oct.) 1965. **2.** Liddle, G. W.: Ann. New York Acad. Sci. *139*:466-470 (Nov.) 1966. **3.** Gantt, C. L.: Diuretic Therapy, DM (Disease-A-Month), Chicago, Year Book Medical Publishers, Inc., 1967, pp. 1-31. **4.** Alexander, S.: Geriatrics 23:131-139 (Nov.) 1968. **5.** Stason, W. B., and others: Circulation *34*:910-920 (Nov.) 1966. **6.** Lieberman, F. L., and Reynolds, T. B.: Gastroenterology *49*:531-538 (Nov.) 1965. 012

SEARLE

Research in the Service of Medicine
G. D. Searle & Co., P.O. Box 5110
Chicago, Illinois 60680

NO UNPLEASANT SURPRISES In G. U. Therapy

Urised does not present unpleasant surprises; it brings patient comfort with first dose pain relief. Unlike newer antibiotics or sulfonamides, Urised does not create problems. It has a time-tested record of minimal side effects. The patient gets additional psychological reassurance of Uriseds effectiveness by the evidence of the blue urine.

For over 50 years Urised has created physician and patient confidence by providing effective therapy when needed.

Clinically effective for G.U. Therapy[1-5]

FIRST DOSE PAIN RELIEF

For G.U. Frequency—Urgency—Burning

URISED®

- **CYSTITIS**
- **PYELITIS**
- **TRIGONITIS**
- **URETHRITIS**

Each blue-coated tablet contains these active ingredients:

Atropine Sulfate	0.03 mg.	Methylene Blue	5.4 mg.
Hyoscyamine	0.03 mg.	Phenyl Salicylate	18.1 mg.
Methenamine	40.8 mg.	Benzoic Acid	4.5 mg.

Contraindications: Glaucoma, urinary bladder neck or pyloric obstruction, duodenal obstruction and cardiospasm. Hypersensitivity to any of the ingredients.

Warning: Do not exceed recommended dosages.

Precautions: Administer with caution to persons with known idiosyncrasy to atropine and cardiac disease. While under this therapy the urine is blue; patients should be so advised to allay apprehension.

Adverse Reactions: Neither irritation nor untoward reactions have been reported; however, if pronounced dryness of the mouth, flushing, or difficulty in initiating micturition occurs, decrease dosage. If rapid pulse, dizziness or blurring of vision occurs, discontinue use immediately. Acute urinary retention may be precipitated in prostatic hypertrophy.

Dosage and Administration: Adults: Two tablets, orally, four times per day, followed by liberal fluid intake. Older children reduce dosage in proportion to age and weight.

How Supplied: Bottles of 50, 500 and 1,000 tablets.

References: (1) Sand, R.X.: New York St. J. Med. 61:2598-2602, 1961: (2) Renner, M.J., et al.: Hosp. Topics 39:71-73, 1961: (3) Haas, J., and Kay, L.L.: Southwest. Med. 42:30-32, 1961: (4) Marshall, W.: Clin. Med. 7:499-502, 1960: (5) Strauss, B.: Clin. Med. 4:307-310, 1957.

CONAL Manufacturers of Uriceutical® Specialties

Pharmaceuticals, Inc.
Chicago, Illinois 60640

E LEADING MANUFACTURER
F INSULIN SYRINGES

B-D

CTON, DICKINSON AND COMPANY
THERFORD, NEW JERSEY 07070

FREE CLINICAL SUPPLY

PLASTIPAK
INSULIN SYRINGE/NEEDLE UNITS

Send samples to:

Name ______________________________
(Physician's Signature

Address ______________________________

City ____________ State ____________ Zip ________

Clip out postcard on dotted line . . . no stamp required

ow you can lower the risk of
nsulin error when your patient is
ome . . . and alone

B-D

SINGLE-USE
PLASTIPAK
INSULIN SYRINGE/NEEDLE UNIT

8401
RED CAP u40

8406
GREEN CAP u80

as specific as insulin itself

Postage
will be paid
by
Addressee

No
postage stamp
necessary
if mailed in the
United States

BUSINESS REPLY MAIL
First Class Permit No. 134, Fairview, N.J.

Becton-Dickinson and Company
Consumer Products Division
P.O. Box 183
Fairview, New Jersey 07022

Clip coupon on dotted line . . . fill out other side
send for physician's free samples

THE LEADING MANUFACTURE
OF INSULIN SYRINGE

B-D

BECTON, DICKINSON AND COMPA
RUTHERFORD, NEW JERSEY 070

color-coded caps and numbers—red for U40, green for U80

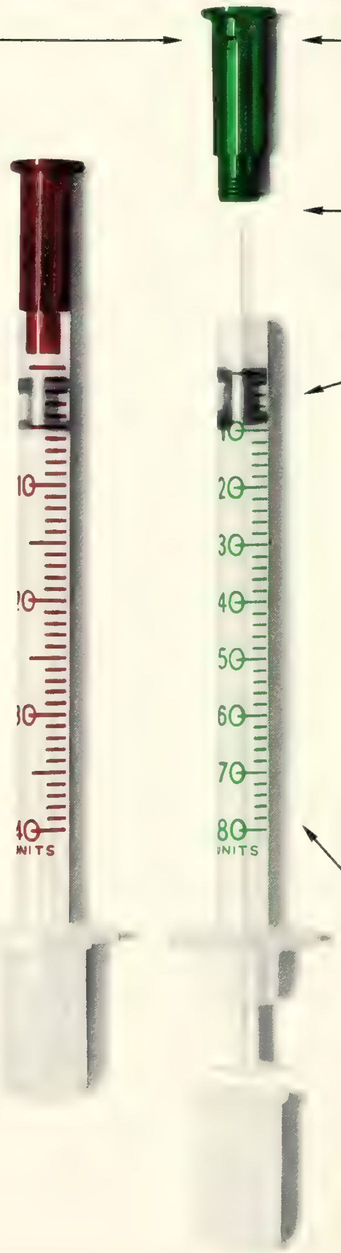
presterilized—consistently dependable, and sterility is assured until cap is opened

easy-to-hold, easy-to-handle—even for child diabetics with small hands or adults with stiff fingers

the sharpest needle your patient can buy—far sharper than any reusable needle

pocket-or-purse portable—sturdy from tip to top

integral cannula reduces air bubbles



single-scale
PLASTIPAK
insulin syringe
needle units
eliminate
the hazard
of reading
the wrong
scale

the first
insulin syringe
so low in cost
your patient
can use
a new one
every time

its single-scale—U40 or U80—minimizes the risk of measurement errors. Your patient *can't* read the wrong scale.

low cost—barely pennies higher than old-fashioned disposable needles without syringe . . . about as low as a cup of coffee

big numbers, wide spaces for easy reading

U40 **U80**

Supplied: in packages of 10—
PLASTIPAK syringe U-40 (red) or
PLASTIPAK syringe U-80 (green)
Prescription required in most states.

BECTON B-D
DICKINSON
Consumer Products Division
Becton, Dickinson and Company
Rutherford, New Jersey 07070

B-D and PLASTIPAK are trademarks

Pri

MSMS Legal Counsel Answers Variety of Queries for Doctors

By A. Stewart Kerr
MSMS Legal Counsel

The office of Legal Counsel is asked to deal with a variety of topics. The most prolific inquiry sources are (1) the MSMS Legal Affairs Committee and (2) doctors and hospital administrators in the smaller communities. In behalf of the Legal Affairs Committee, dozens of statutes and proposed statutes are analyzed each year, covering every conceivable health topic. Inquiries from the smaller communities tend to fall into patterns: hospital staff problems; competent society and hospital bylaws problems; emergency room procedures, and retention of various types of records.

Flipping at random through our 1970 correspondence and opinions, we here note a few of the many interesting topics examined:

1. Ambulance services: equipment requirements, training requirements, and use of two-way radio;
2. Basic Science Act: proposals to amend to render the act inapplicable to doctors of medicine and osteopathy trained in the United States and Canada; questions of outright appeal;
3. Statute permitting treatment of minors for venereal (and other) disease, without parental assent;
4. Michigan Hospital Consent Manual;
5. Medicare freezing of payment rates;
6. Status of physician assistants;
7. Tuition grants to out-of-state students;
8. Truth in Lending Act;
9. Retention and preservation of records; statute of limitations;
10. Administration of intravenous medications;
11. Examinations under the Basic Science Act;
12. Amending Battered Child Statute;
13. Amending Privilege Statute;
14. Possible malpractice arbitration;
15. Solicitation of business;
16. Use of paramedical personnel;
17. Blue Shield forms;
18. Multiphasic screening;
19. County constitutions and bylaws;
20. Drug clinics;
21. Pollution of natural resources;
22. California arbitration: hospital, patient and physician.

Many other topics have been brought to our attention but the above are the items seemingly of the greatest interest, judging by the correspondence that we receive.

It is our pleasure to answer as many inquiries as we can. There are times when it is perplexing to draw the line between our function in serving the general interests of the Society vs. attempting long-distance advice to doctors and administrators who might be better served, legally and ethically, by attorneys in their own communities. We shall continue to perform a lateral arabesque with respect to that problem and service as many of these legitimate inquiries as we possibly can.

Recommendation

The individual physician has the privilege, as well as responsibility, to participate in organized medicine through his county medical society, state medical society and the American Medical Association. But to do his best job he must keep well informed and it is my sincere hope that every physician will devote the comparatively short time that it takes to review his county bulletin, *Michigan Medicine*, the *American Medical News* and *JAMA*.

Brooker L. Masters, M.D., Chairman
MSMS Publication Committee

CONSTIPATION
EVACUATE GENTLY

With EVAC-U-GEN — your patients with functional constipation can evacuate gently. Because EVAC-U-GEN has a mild laxative action and tends to cause the stool to be soft — it is highly desirable for those sensitive to harsh laxatives — particularly children, pregnant women, and geriatric patients. Recommend EVAC-U-GEN for the management of functional constipation. It is highly effective. Non-griping. Chewable. Very palatable. Economical.

EVAC-U-GEN®

A highly-flavored and palatable tablet of yellow phenolphthalein, bismuth subcarbonate, bismuth subgallate in special base. Chewable. Bottles of 35 and 100. Adult Dose: Chew 1 or 2 tablets night or morning. Children (up to age 10): ½ tablet. A citrus drink taken with tablet will stimulate action.
PRECAUTION: Do not use when symptoms of appendicitis are present and discontinue use if skin rash appears. Dependence on laxatives can result from continued use.

W-C PRECISION PHARMACEUTICALS

SEND FOR SAMPLES.

WALKER, CORP & CO., INC.
Syracuse, New York 13201

Michigan Mediscene

Sept. 13 — Michigan Academy of General Practitioners Board Meeting, MSMS Headquarters, 2 p.m.

Sept. 20 — MSMS Council, Sheraton-Cadillac Hotel, Detroit, 9:30 a.m.

Sept. 20-24 — MSMS Annual Session, Sheraton-Cadillac Hotel, Detroit

Sept. 22-24 — 44th Annual Convention of Woman's Auxiliary to MSMS, Pontchartrain Hotel, Detroit

Sept. 23 — MSMS Council, Sheraton-Cadillac Hotel, Detroit

Sept. 24-25 — Michigan Society of Internal Medicine, Otsego Ski Club, Gaylord; Annual Dinner Meeting, Sept. 24; Annual Luncheon, noon, Sept. 25

Sept. 24-27 — Annual Michigan Regional Meeting of the American College of Physicians in association with the Michigan Society of Internal Medicine, Otsego Ski Club, Gaylord

Sept. 26-27 — Annual Fall Educational Seminar, Michigan State Medical Assistants Society, Campus Inn, Ann Arbor

Oct. 5-9 — 53rd Annual Meeting, American Dietetic Association, Detroit

Oct. 5-19 — MSMS Orient Adventure

Oct. 9 — Michigan Association for Regional Medical Programs Annual Meeting, MSMS Headquarters, 1 p.m.

Oct. 11 — Michigan Society of Internal Medicine, MSMS Headquarters, 11 a.m.

Oct. 16-17 — Michigan State Association of Industrial Nurses Fall Conference, Holiday Inn, St. Joseph

Oct. 18-24 — 1970 Community Health Week

Oct. 21-22 — Workshop, Michigan TB and Respiratory Disease Association, Michigan Thoracic Society and Michigan Conference of TB Association Workers, Northland Inn, Southfield

Oct. 22 — MSMS Workshop on Population Control, sponsored by Lay Education Subcommittee of MSMS Committee on Maternal and Perinatal Health, MSMS Headquarters

Nov. 4 — Special meeting of The Council, MSMS Headquarters, noon

Nov. 11 — Michigan Cancer Coordinating Committee, MSMS Headquarters, noon

Nov. 22 — Michigan State Medical Assistants Society, MSMS Headquarters, 11 a.m.

Nov. 29-Dec. 2 — Many Michigan physicians will participate in the annual AMA Clinical Convention in Boston

Dec. 9 — MSMS Council, MSMS Headquarters, 9:30 a.m.

Dec. 9 — 10th Annual Wayne State University Thyroid Workshop, Wayne County Medical Society Auditorium, Detroit

Jan. 30-31 — Annual Winter Educational Seminar, Michigan State Medical Assistants Society, The Ramada Inn, Saginaw

April 30-May 2 — Annual Meeting, Michigan State Medical Assistants Society, Weber's Motor Inn, Ann Arbor

How to Insure Fullest Delivery Of Mental Health Care

(Concluded from Page 749)

pital whenever further intensive treatment is necessary.

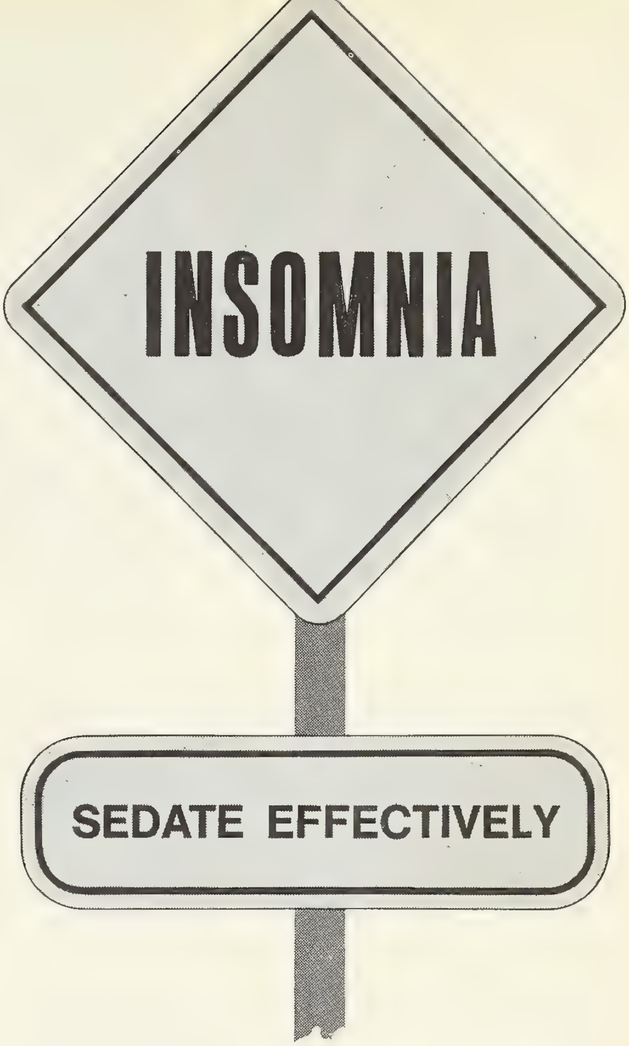
Another point is to stress the importance of keeping some patients in close touch with the hospitals, for instance, by putting them in half-way homes and establishing sheltered workshops controlled by the same hospital staff with which the patient has already formed a therapeutic relation. Such workshops will enable the doctor to see the patient functioning in an optimal environment for quite a long time at the same time that the patient feels that he is contributing something to society. These centers could be the best solution to those patients who remain for quite a long time suffering from the problem of feeling that they can not function unless in an organized hospital setting, and to those institutionalized patients who form a big percentage of the population that mental health professionals deal with nowadays.

These two suggestions will lead to cutting many of the inpatient services that the State presently provides and will direct the efforts towards outpatient services which are more beneficial on the long run, especially after the advent of modern tranquilizers.

(Dr. Al-Najjar is resident psychiatrist at Northville State Hospital.)

The First Reports...

of activities at the 1970 MSMS Annual Session will be presented in the pages of the November *Michigan Medicine* and October *News Extra*. To learn the results of elections and important policy discussions affecting the future of organized medicine in Michigan, read *Michigan Medicine*.



With QUĪ-A-ZONE — you can sedate effectively. A balanced combination of short, intermediate, and long-acting barbiturates (totaling 100 mg.) in a rapidly disintegrating tablet — sedation is provided within a few minutes . . . followed by sound restful sleep . . . usually without morning hangover. The four barbiturates in QUĪ-A-ZONE have dual channels of elimination (renal and hepatic) to lessen metabolic burden, decrease barbiturate retention, and minimize depression.

QUĪ-A-ZONE™

Each rapidly-disintegrating tablet contains 25 mg. secobarbital, 25 mg. pentobarbital, 25 mg. butabarbital, and 25 mg. phenobarbital. Bottles of 100.
Usual Adult Dose: 1 to 2 tablets before retiring.
PRECAUTION: Should not be administered to patients sensitive to barbiturates, or in cases of known previous addiction. Warning: May be habit forming.

W-C PRECISION PHARMACEUTICALS

SEND FOR SAMPLES.

WALKER, CORP & CO., INC.
Syracuse, New York 13201

Wm. C. Baum, M.D., center, explains surgical instruments to two WSU students, Carol Southland and Don Avriett, who spent the summer in Holland. Serving with Doctor Baum to coordinate the rotations was Owen J. Gesink, M.D.

How 11 Michigan Medical Students Spent Summer, 1970

A new head-start program this summer helped 11 Michigan medical students who spent their vacations in hospitals and doctor's offices.

The 10-week demonstration program gave students a first hand look at medical practices and hospital care much earlier in their studies, points out Ross V. Taylor, M.D., Jackson, chairman of the MSMS Council.

This project provided the students with a wider look at hospital operations and the many supportive departments not usually studied by a medical student, adds Doctor Taylor.

The 10 sophomore medical students from Wayne State University and one from the Michigan State University College of Human Medicine helped at seven different hospitals. They were scattered across the state in Northport, Detroit, Plainwell, Grosse Pointe Farms, Holland, Adrian and Greenville.

Gail Paepke, WSU, got experience working at both the Pipp Community Hospital at Plainwell and in the office of Van Keeler, M.D., in Otsego. Doctor Keeler was the medical coordinator there.

"One of the purposes of the projects was to expose the medical students to some of the smaller communities with the hope they may decide later to select a small Michigan town later when they establish their practice," Doctor Taylor points out.

The project was sponsored by the Michigan State Medical Society, the Michigan Hospital Association, and Student American Medical Association Chapters at the three medical schools. Officials of all three schools have approved the project which is scheduled for full-scale operation next summer. Planning for the current project began too late in the spring to include any University of Michigan students this year because their spring term had recessed early.

The project was recommended for the approval of the MSMS Council by the MSMS Education Liaison Committee, John R. Pedden, M.D., Grand Rapids, Chairman.

This project, called by SAMA a "medical education community orientation" was started in 1969 in Illinois, and Michigan was the second state to adopt the project on a pilot basis. A total of six states are participating this year.

The students rotated through the various departments of the community hospitals — pediatrics, surgery, obstetrics, emergency room service, etc., — and most of them also spent time in the office of some physicians, often family physicians. The

ENJOYING A COFFEE BREAK at Northport is John Bruder, right, WSU student, who summered at the Leelanau Memorial Hospital and gained experiences too in the adjacent clinic for migrants. At left is Dwight Schroeder, M.D., Leelanau coordinator.

programs were supervised by physicians representing the medical staffs of the hospitals, and coordinated by hospital administrators. In all cases, the students also saw first hand the operation of many hospital departments such as nursing, medical records, purchasing, labs, etc.

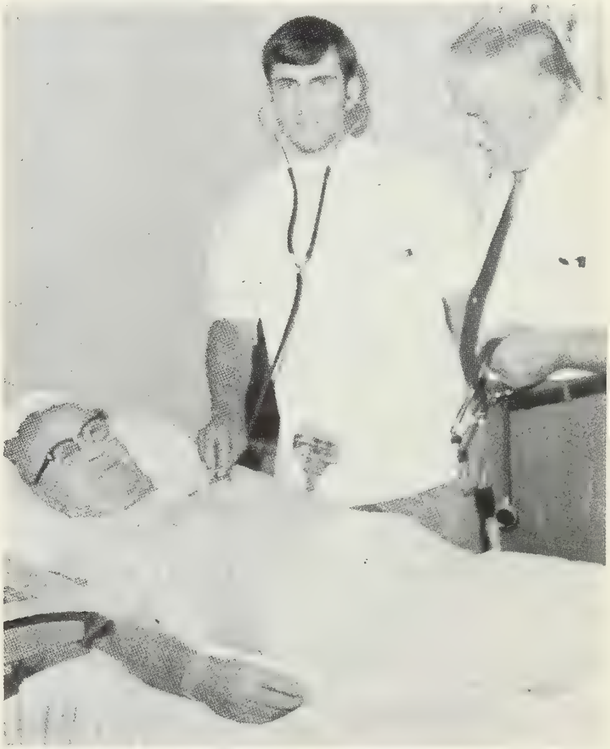
Medical students spend only a limited amount of time with patient care in their first two years and this project was planned to help them learn more about medicine in general before they must make up their minds about what and where to practice.

The students received $75 a week for their services and in most cases were provided room and board by the hospital. The physicians and hospital personnel contributed their time and teaching talent; and at Holland the physicians helped to finance the project.

Following is a list of the participating hospitals and the names of the students:

Randall Riggs, left, was the coordinator for the project for the WSU SAMA chapter. He is shown with Walter Kujawski, M.D., who directed the project at Cottage Hospital at Grosse Pointe Farms where Randy helped.

Adrian, Emma L. Bixby Hospital — Ronald Zack (WSU)
Detroit, Hutzel Hospital — Steven Crane (WSU), Michael Geheb (WSU), Robert Urban (WSU), and Richard Valentine (WSU)
Greenville, United Memorial Hospital — Anson Goodier (MSU)
Grosse Pointe Farms, Cottage Hospital — Randall Riggs (WSU)
Holland, Holland City Hospital — Don Avriett (WSU), Carol Southland (WSU)
Northport, Leelanau Memorial Hospital — John Bruder (WSU)
Plainwell, Pipp Community Hospital — Gail Paepke (WSU)



REPRESENTING MSU in the program was Anson Goodier who helped at the United Memorial Hospital in Greenville. Robert E. Rice, M.D., was the program director for the project there.

about doctors

Neil F. Bracht is director of social work at the new Child Development and Mental Retardation Center at the University of Washington, Seattle. Mr. Bracht was associate professor and assistant dean of the College of Human Medicine at Michigan State University until Aug. 1.

William D. Cheney, M.D., Detroit, heads the Detroit Roentgen Ray Society. Other officers are Ernest P. Griffin, Jr., M.D., and David P. Corbett, M.D., secretary-treasurer.

William R. Chynoweth, M.D., Battle Creek, retired June 1 after 53 years as a practicing physician. A surgeon and specialist in urology, Doctor Chynoweth was a personal friend of the late Dwight D. Eisenhower. He is still a staff member of the Battle Creek Sanitarium.

James F. Dooley, M.D., Grand Blanc, is new president of the Michigan Academy of General Practice. He succeeds Douglas A. Haddock, M.D., of Kalamazoo. Named president-elect at the academy's Congress of Delegates is Joseph V. Fisher, M.D., of Chelsea, while Robert L. Vitu, M.D., Saginaw was selected speaker of the Congress.

Tommy N. Evans, M.D., Detroit, acting dean of the WSU School of Medicine, is a member of a subcommittee to Detroit Mayor Roman Gribb's Health Care Advisory Committee. The subcommittee is to advise the mayor on development of a new hospital in the Medical Center corridor of Detroit.

William Jend, Jr., M.D., Bloomfield Hills, is new vice president of the Industrial Medical Association. He is medical director of the Michigan Bell Telephone Co.

Richard E. Olsen, M.D., Pontiac, is at home in Luzerne, in the northern Lower Peninsula, following his retirement as Oakland County's chief deputy medical examiner. He has served as pathologist for all four hospitals in Pontiac, where he has worked since 1930.

Ernest Rondot, M.D., Stoney Point, Ontario, who was a Mt. Pleasant-area physician for 55 years, recently marked his 100th birthday. Doctor Rondot, who retired 22 years ago, was honored with a party in Windsor, Ontario, attended by the first of more than 3,800 babies he delivered.

L. O. Shantz, M.D., Flint, has retired after 39 years of service as a general practitioner. He is a past president of the Genesee County Medical Society, former chief of Hurley Hospital medical staff and former president of the Michigan Academy of General Practitioners.

L. Murray Thomas, M.D., Detroit, has been appointed acting chairman of the department of Neurosurgery at the Wayne State University School of Medicine. He succeeds Elisha S. Gurdjian, M.D., who retired July 1 after serving 31 years on the WSU Medical Faculty.

H. C. Tien, M.D., Lansing, is founding editor-in-chief of the *World Journal of Psychosynthesis,* which he founded and has been publishing since October. Doctor Tien heads a 20-man board of contributing editors and receives articles from 25 international editorial correspondents. The journal is published in East Lansing and is sponsored by the Michigan Institute of Psychosynthesis.

Three physicians at Midland Hospital are recipients of the Doctor Harry A. Towsley Awards for interns and residents showing outstanding accomplishment. The award was established in 1967 by the five daughters of Doctor Towsley, chairman of the Department of Postgraduate Medical Education at U-M. The recipients of the 1970 awards are Phillip B. Shepard, M.D., A. Leslie Rose, M.D., and Gordon R. Patton, M.D.

Raymond W. Waggoner, M.D., has retired after 33 years as chairman of the University of Michigan Department of Psychiatry and director of the University's Neuropsychiatric Institute. He will continue to teach in the department for one year and will serve as a consultant to the Reproductive Biology Research Foundation of St. Louis, Mo. A special resolution was passed by the Michigan Senate to honor Doctor Waggoner and a testimonial dinner was held in Ann Arbor.

Alfred H. Whittaker, M.D., Detroit, is new president of the American Medical Writer's Association, Michigan chapter. Other new officers are Charles W. Sellers, M.D., Detroit, secretary, and C. Howard Ross, M.D., Ann Arbor, trustee.

Pat Hudson has angina.
But he hardly ever thinks about it.

New

STEPS™

PENTAERYTHRITOL TETRANITRATE

Timed Disintegration Capsules

Give him prophylaxis against angina pectoris
Convenience of twice-a-day dosage
Greater peace of mind

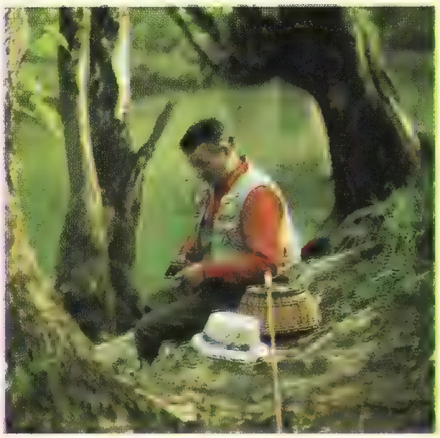
Each capsule is designed to provide vasodilating effect for up to 12 hours. Conventional dosage forms of pentaerythritol tetranitrate (PETN), which must be taken every 3 to 4 hours, keep some patients reminded of their disability throughout the day. And some, taking short-acting dosage forms, become quite apprehensive about being without medication while asleep.

Dosage range that now lets you control nitrite therapy.

STEPS pentaerythritol tetranitrate timed disintegration capsules not only give the patient more convenience and peace of mind, they let you prescribe the dose an individual patient needs.

STEPS comes in 3 potencies—30 mg. 50 mg. and 80 mg.—to help you determine the optimal level of effectiveness in providing relief from the frequency and intensity of anginal attacks.

The wide potency range of STEPS allows you to adjust the dosage to meet the patient's needs. Moreover, if therapy must be altered or discontinued due to nitrite tolerance, the flexible dosage of STEPS permits resumption of therapy at the smallest effective dose.



(See next page for complete dosage recommendations and precautions.)

New

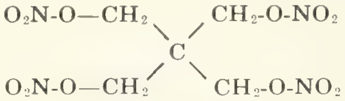
STEPS™ PENTAERYTHRITOL TETRANITRATE

Timed Disintegration Capsules

Available in three potencies for greater dosage flexibility and better control of therapy.

CAUTION: Federal law prohibits dispensing without prescription.

DESCRIPTION: Pentaerythritol Tetranitrate Structural Formula:



Empirical Formula: $C_5H_8N_4O_{12}$ Molecular Weight: 316.15. The pentaerythritol tetranitrate is in a special timed disintegration base providing for prolonged therapeutic effect.

MODE OF ACTION: The mechanism of action in the relief of angina pectoris is unknown at this time, although the basic pharmacologic action is to relax smooth muscle.

INDICATIONS: For the relief of angina pectoris (pain of coronary artery disease). It is not intended to abort the acute anginal episode, but is widely regarded as useful in the prophylactic treatment of angina pectoris.

CONTRAINDICATIONS: Idiosyncrasy to this drug.

WARNINGS: Data supporting the use of nitrites during the early days of the acute phase of myocardial infarction (the period during which clinical and laboratory findings are unstable) are insufficient to establish safety. Keep out of reach of children.

PRECAUTIONS: Intraocular pressure is increased; therefore, caution is required in administering to patients with glaucoma. Tolerance to this drug, and cross-tolerance to other nitrites and nitrates may occur.

ADVERSE REACTIONS: Cutaneous vasodilation with flushing. Headache is common and may be severe and persistent. Transient episodes of dizziness and weakness, as well as other signs of cerebral ischemia associated with postural hypotension, may occasionally develop. This drug can act as a physiological antagonist to norepinephrine, acetylcholine, histamine, and many other agents. An occasional individual exhibits marked sensitivity to the hypotensive effects of nitrite and severe responses (nausea, vomiting, weakness, restlessness, pallor, perspiration and collapse) can occur, even with the usual therapeutic dose. Alcohol may enhance this effect. Drug rash and or exfoliative dermatitis may occasionally occur.

DOSAGE AND ADMINISTRATION: One capsule every 12 hours on an empty stomach. (Not recommended for sublingual use.)

HOW SUPPLIED: STEPS pentaerythritol tetranitrate timed disintegration capsules are available in 30 mg. (NDC 183-504-2), 50 mg. (NDC 183-505-2), and 80 mg. (NDC 183-506-2) sizes. Each capsule size is packaged in bottles of 100.

STORAGE: Capsules should be stored in a cool, dry place in a light-resistant container out of the reach of children.

30 mg.
50 mg.
80 mg.

THE DOW CHEMICAL COMPANY
Rx Pharmaceuticals, Indianapolis

The girth control pill

Tepanil® Ten-tab(H)

(continuous release form)

(diethylpropion hydrochloride)

works on the appetite not on the 'nerves'

When girth gets out of control, TEPANIL can provide sound support for the weight control program you recommend. TEPANIL reduces the appetite—patients enjoy food but eat less. Weight loss is significant—gradual—yet there is a relatively low incidence of CNS stimulation.

Contraindications: Concurrently with MAO inhibitors, in patients hypersensitive to this drug; in emotionally unstable patients susceptible to drug abuse.

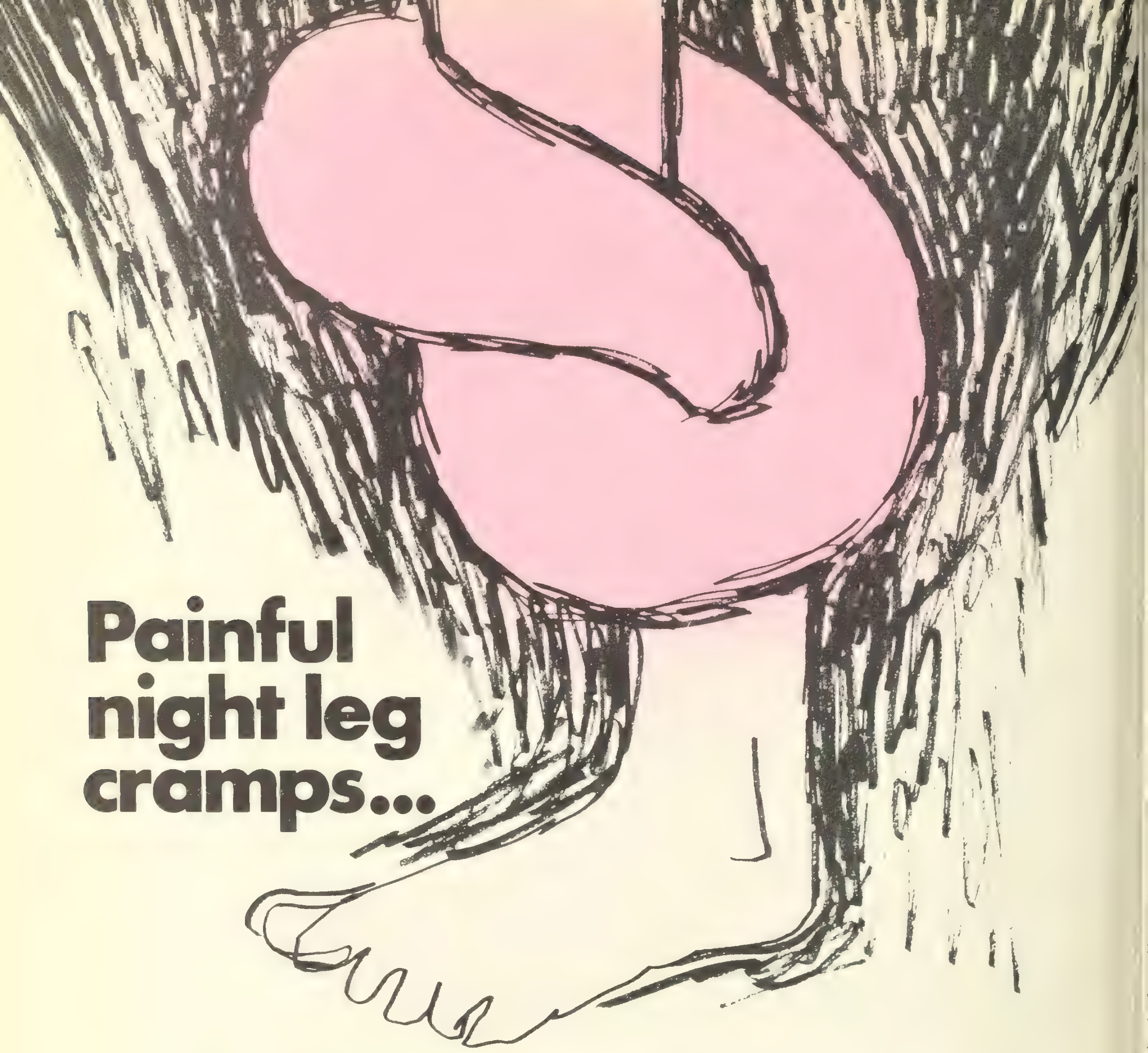
Warning: Although generally safer than the amphetamines, use with great caution in patients with severe hypertension or severe cardiovascular disease. Do not use during first trimester of pregnancy unless potential benefits outweigh potential risks.

Adverse Reactions: Rarely severe enough to require discontinuation of therapy, unpleasant symptoms with diethylpropion hydrochloride have been reported to occur in relatively low incidence. As is characteristic of sympathomimetic agents, it may occasionally cause *CNS effects* such as insomnia, nervousness, dizziness, anxiety, and jitteriness. In contrast, CNS depression has been reported. In a few epileptics an increase in convulsive episodes has been reported. *Sympathomimetic cardiovascular effects* reported include ones such as tachycardia, precordial pain, arrhythmia, palpitation, and increased blood pressure. One published report described T-wave changes in the ECG of a healthy young male after ingestion of diethylpropion hydrochloride; this was an isolated experience, which has not been reported by others. *Allergic phenomena* reported include such conditions as rash, urticaria, ecchymosis, and erythema. *Gastrointestinal effects* such as diarrhea, constipation, nausea, vomiting, and abdominal discomfort have been reported. Specific reports on the hematopoietic system include two each of bone marrow depression, agranulocytosis, and leukopenia. A variety of miscellaneous adverse reactions have been reported by physicians. These include complaints such as dry mouth, headache, dyspnea, menstrual upset, hair loss, muscle pain, decreased libido, dysuria, and polyuria.

Convenience of two dosage forms: TEPANIL Ten-tab tablets: One 75 mg. tablet daily, swallowed whole, in midmorning (10 a.m.); TEPANIL: One 25 mg. tablet three times daily, one hour before meals. If desired, an additional tablet may be given in midevening to overcome night hunger. Use in children under 12 years of age is not recommended.

T-006A / 1/70 / U.S. PATENT NO. 3,001,910

THE NATIONAL DRUG COMPANY
DIVISION OF RICHARDSON-MERRELL INC
PHILADELPHIA, PENNSYLVANIA 19144



Painful night leg cramps...

unwelcome bedfellow for any patient—including those with arthritis, diabetes or PVD

One thing patients can sleep without, particularly patients with chronic disease conditions such as arthritis, diabetes or PVD, is painful night leg cramps. Although seldom the presenting complaint, night leg cramps can tie your patients up in painful knots. Now, just one tablet of QUINAMM at bedtime can usually bring an end to shattered sleep and needless suffering. Your patients will sleep restfully—gratefully—with QUINAMM, specific therapy to prevent painful night leg cramps.

Prescribing Information—Composition: Each white, beveled, compressed tablet contains: Quinine sulfate, 260 mg., Aminophylline, 195 mg. **Indications:** For the prevention and treatment of nocturnal and recumbency leg muscle cramps, including those associated with arthritis, diabetes, varicose veins, thrombophlebitis, arteriosclerosis and static foot deformities. **Contraindications:** QUINAMM is contraindicated in pregnancy because of its quinine content. **Precautions/Adverse Reactions:** Aminophylline may produce intestinal cramps in some instances, and quinine may produce symptoms of cinchonism, such as tinnitus, dizziness, and gastrointestinal disturbance. Discontinue use if ringing in the ears, deafness, skin rash, or visual disturbances occur. **Dosage:** One tablet upon retiring. Where necessary, dosage may be increased to one tablet following the evening meal and one tablet upon retiring. **Supplied:** Bottles of 100 and 500 tablets.

THE NATIONAL DRUG COMPANY
DIVISION OF RICHARDSON-MERRELL INC.
PHILADELPHIA, PENNSYLVANIA 19144

Quinamm™ Specific therapy for night leg cramps

(quinine sulfate 260 mg., aminophylline 195 mg.)

Many New Proposals Of Health Care Legislation

By Herbert Mehler, Staff Assistant
MSMS Committee on
Governmental-Medical Care Programs

Federal Activity

Environmental Reorganization: The President submitted to Congress "Reorganization Plan No. 3" to reorganize and consolidate federal environmental programs under the administration of an environmental protection agency. This agency will: (1) establish and enforce standards consistent with national and environmental goals; (2) research adverse effects of pollution and seek methods and equipment for controlling; (3) aid public and private groups and organizations, through grants, technical assistance, etc. to control and abate pollution; and (4) assist the Council on Environmental Quality to develop and recommend new policies. The plan becomes effective in 60 days unless Congress has specific objections.

Health Training Improvement Act of 1970: The Senate passed SB 3586 – extension of the Allied Health Professions Assistance Act by authorizing funds for (1) construction of training facilities; (2) improvement of allied health curricula; (3) special improvement grants; (4) advance traineeships to train teachers; and (5) developmental grants to develop and evaluate new types of health personnel. The bill is now in the House.

Family Planning: The Senate passed SB 2108, the Family Planning and Research Act, which creates a new post of Deputy Assistant Secretary of HEW; makes voluntary services available to every citizen, although primarily directed to an estimated 5 million indigent women for whom unwanted children are considered a particular hardship; expands research in reproduction; provide for the development of new, safe, and effective contraceptives; and provides grants for training of manpower to conduct programs. This bill is now in the House.

Proposals to improve and expand the delivery of health care continue in Washington and Lansing. This article briefs legislative and agency activity that will affect the profession and your practice, if adopted. Bills not enacted this year will likely be introduced early in 1971. Your comments and requests for additional information are invited.

Family Practice: Hearings are scheduled on SB 3418 by the Subcommittee on Health of the Senate Labor and Public Welfare Committee which would establish a 5-year program of assistance to public and private nonprofit medical schools and hospitals to expand or establish new programs of training. Bill calls for 12-member Advisory Council on Family Medicine to include four practicing family practitioners.

Other Legislative Action: The House passed HR 18127 which appropriates funds for the Public Works and Atomic Energy Commissions that includes funds to develop a nuclear powered artificial heart; the Special Subcommittee on Alcoholism and Narcotics approved SB 3835 which provides for a comprehensive program for prevention and treatment of alcohol abuse and alcoholism; a bill will be introduced entitled "Professional Standards Review Organization Act of 1970" which would authorize creation of a review group of physicians to be responsible for reviewing totality of care, including institutional care, provided to patients. Basic responsibility will be placed, when possible and feasible, at the local community level with priority to local medical societies, if willing and of suitable size, to undertake the review function.

Medicare Reimbursement: The Social Security Administration has informed carriers to continue paying physicians at the 83rd percentile until the U.S. Senate has considered a House bill, passed in May, which calls for Part B payments at the 75th percentile beginning in July, 1970.

American College of Obstetrics & Gynecology: Received an Office of Economic Opportunity (OEO) grant to select 10 big hospitals that serve at least 10,000 poor people to conduct a family planning project.

McNerney Task Force on Medicaid and Related Programs Report: ". . . . . . all consumers should have access to health care without hardship or humiliation and . . . . . . some voice in how it is planned and some choice of how it is furnished"; "health care delivery system cannot function effectively in response to consumer demand and provider self-interest but must be planned and managed so that the terms and conditions of payment shall have a powerful impact on the way the services are organized and delivered."

Other recommendations are: Inclusion under Medicare of totally and permanently disabled Social Security beneficiaries; consumer representation on any group set up to advise policy-making officials at any level of government; reimbursement to hospitals and other providers under Medicare and Medicaid on a prospective rather than on a retrospective basis; development of Medicaid program-effectiveness systems by the states; adequate funding for Comprehensive Health Service Planning agencies and the appointment of a high-level body to promptly study the development of a health-care financing policy.

Michigan Comprehensive Health Planning:

The State Advisory Council will recommend to the Governor the creation of a new state agency which would abolish the State Commission by incorporating members of the Commission into the Advisory Council. The Advisory Council reasoned that this program should be centered in a single, strong agency with sufficient staff and authority to effectively integrate all components of health planning; the Agency should be headed by a competent, qualified Director with a salary comparable to other Department heads; should have direct access to the Executive Office; would increase Advisory Council representation by permitting one consumer representative from each organized areawide advisory council and add areawide council directors as ex-officio members but without vote. The State Advisory Council adopted a resolution to oppose Michigan Senate Bill 1756 (chiropractic services under Blue Shield) and to convey this opposition to the Governor.

State Office Of Economic Opportunity Grants:

The Executive Office approved funding to the Inter Tribal Councils of Michigan for emergency food, medical services and economic development; and to the Chippewa-Luce-Mackinac Community Action Agency, Alger-Marquette Community Action Board and the Menominee-Delta-Schoolcraft Community Action Agency for alcoholism programs.

MAILBAG

'We Cannot Muffle Dissent from Students,' Writes Doctor Raven

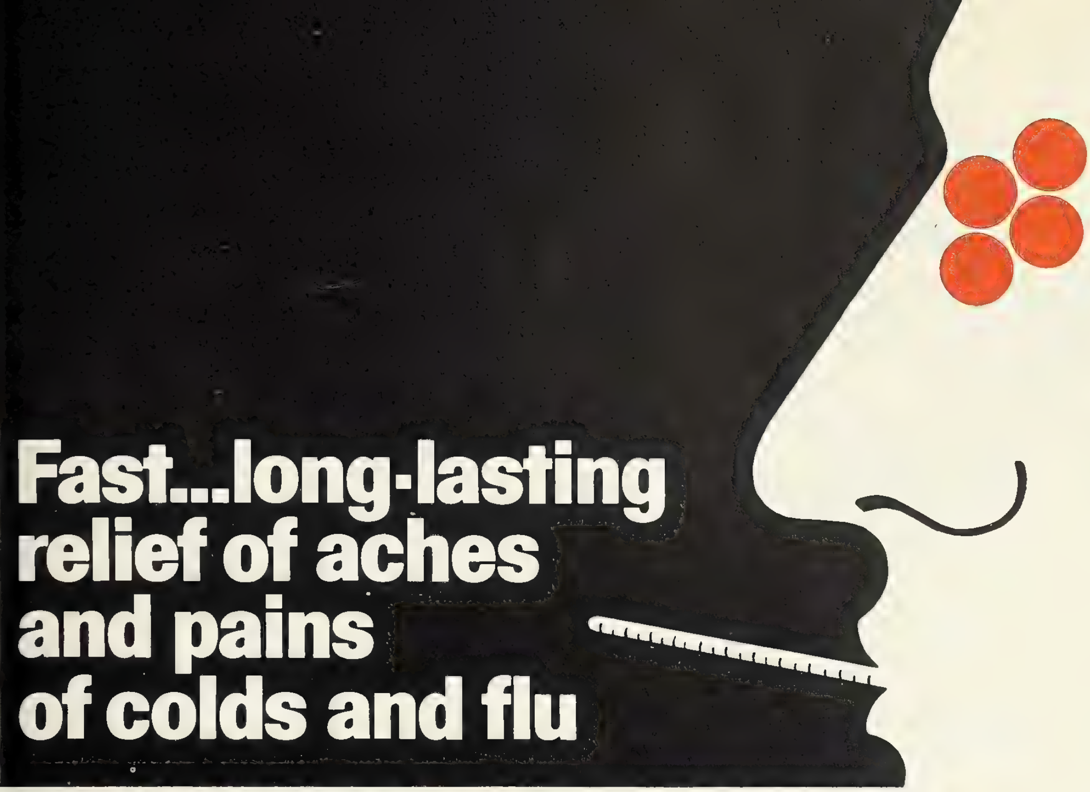
To the Editor:

I read with interest the letters from WSU and MSU students as well as letters from Doctor Morley and Doctor Esslinger. I am also happy to learn that the number of women medical students has been on an increase over the past five years. As chairman of the public health committee of the American Medical Women's Association I was happy to have a number of pertinent resolutions voted favorably by the House of Delegates at the annual meeting of AMWA last November. Briefly these were as follows:

* Urged incorporation of family planning and counseling into the framework of basic health services.
* Approved sex education in schools if taught discretely within the life sciences, hygiene and biology, supplementing religious and ethical teaching at home.
* Endorsed liberalization of abortion and voluntary sterilization laws.
* Recommended that the Association of Medical Schools require the *"Teaching of Social and Ethical and Moral Roles of Physicians in Society."*
* Endorsed programs to provide comprehensive health care for the poor and some form of voluntary health insurance for all ages.
* Suggested that the Membership of AMWA get increasingly involved in community activities and public policy making legislation.
* Resolved to undertake a special study of the basic causes of crime, violence and civil disobedience, and aim to alleviate the social unrest in our nation.

We cannot muffle dissent from students, especially medical students, who are recognizing the close inter-relationship between health and quality of life as a whole. Their definition of health includes not only physical and mental, but also social well-being. They are hoping for serious involvement by their peers.

Clara Raven, M.D., F.C.A.P.
Until recently, Deputy Chief
Medical Examiner of Wayne County



Fast...long-lasting relief of aches and pains of colds and flu

with the unique timed-release aspirin

Double strength Measurin timed-release aspirin offers a new kind of control for your patients with cold and flu discomforts. In each 10-grain tablet are over 6,000 microscopic reservoirs that release aspirin at a controlled rate—some right away and some later on. This means fast relief of symptoms, followed by hours of comfort. Throughout the day, Measurin gives your patients freedom from a 4-hour aspirin schedule. During the night, its 8-hour dosage schedule holds the promise of sound sleep without awakening to take extra tablets.

For Professional Samples write:
Breon Laboratories Inc.
Sample Fulfillment Division
P.O. Box 141
Fairview, N.J. 07022

BREON **BREON LABORATORIES INC.**
90 Park Avenue, New York, N.Y. 10016
Subsidiary of Sterling Drug Inc.

MEASURIN®
TIMED-RELEASE ASPIRIN
ECONOMICAL • EFFECTIVE • LONG LASTING PAIN RELIEF
Dosage: 2 tablets followed by 1 or 2 tablets every 8 hours as required, not to exceed 6 tablets in 24 hours. For maximum nighttime pain relief, 2 tablets at bedtime.
Available: Bottles of 12, 36 and 60 tablets.

welcome

New Members

Members of the Michigan State Medical Society join in welcoming the following new members into a progressive state medical organization. MSMS is dedicated to promoting the science and art of medicine, the protection of the public health, and the betterment of the medical profession. Each new member is encouraged to join with other MSMS members at both the local and the state levels in achieving these goals.

Thomas E. Finch, MD, 1122 E. Front St., Traverse City 49684
Wm. H. Johnson, MD, Health Ctr. — WMU, Kalamazoo 49001
Wm. E. McNally, MD, 325 E. Centre St., Portage 49081
Garth Shultz, MD, 217 Bronson Med. Ctr., Kalamazoo 49006
Charles F. Gehrke, MD, St. Joseph Mercy Hosp., Ann Arbor 48104
John B. Hannah, MD, Matthews Building, Owosso 48867
William J. Murray, MD, Univ. Medical Center, Ann Arbor 48104
Richard H. Berg, MD, 162 Second St., Sunfield 48890
Donald D. Burkley, MD, P.O. Box 428, Grayling 49738
Dolores B. Storey, Ph.D., 2011 Apple Ave., Muskegon 49442
Willard M. Stuckey, MD, 2565 Mershon St., Saginaw 48602
Hector A. Baleiron, MD, 987 E. Jefferson, Detroit 48207
Donald W. Bower, MD, 3725 Fort, Lincoln Park 48146
Abdul S. Choudhry, MD, 17533 Fort St., Riverview 48192
Wm. N. Davis, MD, 1250 Middlebelt Rd., Inkster 48141
Daniel Deitch, MD, Kirwood General Hospital, Detroit 48238
John P. Flanders, MD, 5347 Questa Tierra Dr., Phoenix, Ariz. 85012
Gurdev S. Garewal, MD, Detroit Memorial Hospital, Detroit 48226
Thelma H. McQuiggan, MD, 1250 Middlebelt, Inkster 48141
Jimmy Mistry, MD, Mercy Hospital, Monroe 48161
Anthony C. Pagedas, MD, 2081 Monroe, Dearborn 48124
Prital S. Puri, MD, Wayne State Univ., Detroit 48207
Albert Shemtob, MD, 12010 Linwood, Detroit 48206
Dean T. Smith, MD, 2111 Eastern Ave., N.E., Grand Rapids 49505
Ertugrul Tekisalp, MD, 32300 Schoolcraft, Livonia 48150
David Greenbaum, M.D., Dept. of Medicine, College of Human Medicine, Michigan State University, East Lansing 48823
Donald E. Knickerbocker, M.D., 1017 E. Grand River Ave., East Lansing 48823
Harry Mohammed, M.D., Health Center, Ferris State College, Big Rapids 49307
William H. S. Moore, M.D., 1201 Flushing Road, Flint 48504
M. Gary Robertson, M.D., 1310 Wisconsin Avenue, Grand Haven 49417
Konrad A. Garstka, M.D., 130 Carpenter St., West Branch 48661
Romulo E. Silva, M.D., 209 North Walnut, Lansing 48933
Elie R. Khoury, M.D., 3027 N. Woodward Ave., Royal Oak 48072
Henry D. Appelman, M.D., University Medical Ctr., Ann Arbor 48104
Daniel J. Fall, M.D., St. Joseph Mercy Hospital, Ann Arbor 48104
David W. Hunter, M.D., Univ. Medical Ctr., Ann Arbor 48104
Wolfgang May, M.D., Box A, Ypsilanti 48197
Terence J. McDonnell, M.D., Univ. Medical Center, Ann Arbor 48104
Stanley R. Strasius, M.D., St. Joseph Mercy Hospital, Ann Arbor 48104
I. Turan Bengisu, M.D., 1615 Genesee Towers, Flint 48502
Paul J. Brat, M.D., 245 Warwick Drive, Alma 48801
Harland C. Dangle, M.D., 673 W. Fennville St., Fennville 49408
Gerald L. Groat, M.D., Deckerville 48427
Hector J. Inchaustegui, M.D., 4045 West 13 Mile Rd., Royal Oak 48072
Richard L. Jankowska, M.D., 2110 — 16th St., Bay City 48706
W. Patrick Mazier, M.D., 72 Sheldon Ave., S.E., Grand Rapids 49502
Jimmy Mistry, M.D., Mercy Hospital, Monroe 48161
Elli Moeller-Fabok, M.D., 602 E. Pottawatamie St., Tecumseh 49286
Lacey Walke, M.D., 214 David Whitney Bldg., Detroit 48226
Robert W. Wesche, M.D., Berrien General Hosp., Berrien Center 49102

Lavern V. Wolfgram, M.D., 1209 E. Eighth St., Traverse City 49684
David A. Bowman, M.D., 1815 Wm. H. Taft Rd., Cincinnati, Ohio 45206
Peter E. Carmody, M.D., 813 Lincoln Dr., Hancock 49930
Joel M. Kriegel, M.D., 35992 Gratiot Ave., Mt. Clemens 48043
Evangeline J. Spindler, M.D., Univ. of Michigan – C.P.H., Ann Arbor 48104
Donald J. Allcorn, M.D., 1279 Coldwater Rd., Flint 48505
Robert E. Stelle, M.D., 701 State, Crystal Falls 49920
Mary O. Anderson, MD, 202 Millard, Three Rivers 49093
Robert Anderson, MD, Dickinson Memorial Hosp., Iron Mountain 49801
Wm. B. Anderson, MD, 966 Fisher Bldg., Detroit 48202
Joseph N. Aquilina, MD, 3406 Davenport, Saginaw 48602
Mohammad A. Ariani, MD, 3800 Woodward Ave., Detroit 48201
John D. Baker, MD, Detroit Gen. Hospital, Detroit 48226
George T. Bradley, MD, 3800 Woodward Ave., Detroit 48201
Nora Chang, MD, Children's Hospital, Detroit 48202
Dale D. J. Chodos, MD, Upjohn Company, Kalamazoo 49001
Basil Considine, Jr., MD, Harper Hospital, Detroit 48201
Michael Coyne, MD, 1414 W. Fair Ave., Marquette 49855
John H. Day, MD, 1787 Newcastle, Grosse Pte. Woods 48236
Robert P. DeClark, MD, 50 College Ave., SE, Grand Rapids 49503
William L. Doss, MD, 10145 E. Jefferson, Detroit 48214
Merle L. Dykema, MD, 2301 Riverside Dr., N.E., Grand Rapids 49505
F. E. Erlandson, MD, 121 E. Ludington Ave., Ludington 49431
William J. Foley, MD, University Medical Ctr., Ann Arbor 48104
Peter C. Gay, MD, 2704 Georgetown Dr., Midland 48640
Donald W. Goin, MD, St. Joseph Mercy Hospital, Ann Arbor 48104
Floyd G. Goodman, MD, 4528 S. Hagadorn Rd., East Lansing 48823
Kare Gundersen, MD, Upjohn Company, Kalamazoo 49001
Marietta J. Kaylor, MD, 412 Water St., Allegan 49010
Mohamed J. Khan, MD, Sparrow Hospital ER, Lansing 48902

painless intramuscular therapy for calcium deficiencies:

Calphosan®

calcium glycerophosphate, calcium lactate

To bring effective calcium therapy to the patient, Calphosan may be administered intramuscularly . . . without pain, inflammatory reactions, induration or sloughing. Injections twice weekly for a series of 5 to 10 injections are recommended.

Average dose per injection: One or two 10 ml. injections of Calphosan each week for the first four or five weeks, and on a when-needed basis thereafter.

Calphosan is a specially processed solution of calcium glycerophosphate and calcium lactate, containing 1% of each, in a physiological solution of sodium chloride. Each 10 ml. contains 50 mg. of calcium glycerophosphate, 50 mg. calcium lactate, with 0.25% phenol as preservative. Available in 10 ml. ampules in boxes of 10s and 100s; 60 ml. multiple-dose vials. Also available as Calphosan with B-12. U. S. Patent No. 2657172.

Contraindication: Hypercalcemia; neoplastic diseases; and fully digitalized patients. Do not use intramuscularly in infants and young children. Before starting therapy, consult complete product literature.

Write for free copy of "Calcium: The Ubiquitous and Essential Element" and for samples.

THE CARLTON CORP

Tenafly, New Jersey 07670

James Kiess, MD, 308 N. Broad St., Adrian 49221
Glenn W. Kindt, MD, University Medical Ctr., Ann Arbor 48104
Richard L. Kreuzer, MD, 470 Tuttle, SE, Grand Rapids 49503
Donald H. Kuiper, MD, Dept. of Med. — MSU, East Lansing 48823
Raymond J. Lovett, Jr., MD, 1320 Plymouth Rd., S.E., Grand Rapids 49506
William F. Malarney, MD, 880 Woodward Ave., #106, Pontiac 48053
Vincent Mazzarella, MD, 207 Fletcher, Ann Arbor 48104
Gideon deLeon Medina, MD, 7440 Poe St., Detroit 48206
Hugh H. Miley, MD, Wayne County General Hosp., Eloise 48132
Allen B. Moore, MD, 1106 S. Madison St., Bay City 48706
Roger M. Morrell, MD, 4016 Nichols Rd., Kalamazoo 49001
Kenneth H. Musson, MD, 1517 Arborview Blvd., Ann Arbor 48103
Robert T. Nolta, MD, 1805 Veterans Memorial Parkway, Saginaw 48601
Antonio S. Nucum, MD, 5725 Tipperary Trail, Waterford 48095
David E. Ojeda, MD, 3169 W. Pierson Rd., Flint 48504
Joseph M. Price, MD, 9905 S. Gera Road, Birch Run 48415
Sanford J. Rautbort, MD, 96 Barrington Rd., Bloomfield Hills 48013
Vangala P. Reddy, MD, 292 E. Chicago St., Coldwater 49036
Robert A. Sheiman, MD, Univ. Med. Ctr., Ann Arbor 48104
Reza Mohajer-Shojaee, MD, 481 Miller, Rochester 48063
Milton Soderberg, MD, 1414 W. Fair Ave., Marquette 49855
Lowell Somers, MD, Box 98, Florence, Wisconsin 54121
Mary A. Soule, MD, 166 North Glenhurst, Birmingham 48009
John M. Stone, MD, 1665 Twelve Mile Rd., Berkley 48072
Glenn P. Verbrugge, MD, 468 Tuttle Ave., N.E., Grand Rapids 49503
Lloyd A. Walwyn, MD, 1147 Cooper St., S.E., Grand Rapids 49507
Harvey I. Wilner, MD, Harper Hospital, Detroit 48201
Dale A. Wilson, MD, 2765 Flushing Rd., Flint 48504
Richard J. Bing, MD, 100 Congress St., Huntington Memorial Hosp., Pasadena, Calif. 91105
Carole B. Boyd, MD, 1400 Chrysler Expwy., Detroit 48207
Robert W. Brownlee, MD, 1631 Gull Road, Kalamazoo 49001
Mary V. Daly, MD, 201 River St., Albion 49224
M. Ekrem Dimbiloglu, MD, 1018 North Ave., Battle Creek 49017
Warren E. Emley, MD, University Medical Center, Ann Arbor 48104
Wm. G. Fritschel, MD, 109 W. Erie St., Albion 49224
Robert I. Gans, MD, 26615 Greenfield, Southfield 48075
Ronald Grant, DDS, 208 Medical Arts Ctr., Muskegon 49440
Narciso O. Inez, MD, 3800 Woodward Ave. #612, Detroit 48201
Stephen P. Kahn, DDS, 1810 Ruddiman Dr., North Muskegon 49445
James M. Kuhlman, MD, 3800 Woodward Ave., Detroit 48201
Anthony Martinez, MD, Chrysler Corp., Highland Park 48203
I. Wm. McLean, Jr., MD, Parke, Davis & Co., Joseph Campau at River, Detroit 48232
Thomas A. McLennan, MD, 913 Mott Foundation Bldg., Flint 48502
Elwin W. Midgley, MD, 60 W. Hancock, Detroit 48201
Azorides R. Morales, MD, Henry Ford Hospital, Detroit 48202
Delbert P. Nachazel, Jr., MD, 3800 Woodward Ave., Detroit 48201
Lonie B. Ocdol, MD, 1449 David Whitney Bldg., Detroit 48226
Ruitson Ouyang, MD, 3083 Flushing Rd., Flint 48504
Gurdon R. Patton, MD, 2707 Ashman, Midland 48640
Imbi Ralyea, MD, Medical Arts Bldg., Cadillac 49601
Peter S. Schidlowsky, MD, 18917 Shadyside, Livonia 48152
Frederick M. Worley, Jr., MD, 987 E. Jefferson, Detroit 48207
Seymour Ziegelman, MD, 15901 W. Nine Mile Rd., Southfield 48075
Lawrence L. Stocker, MD, 36615 Greenfield, Southfield 48075
Liboria Tranchida, MD, Detroit General Hosp., Detroit 48226
Alaollah Zahed, MD, 39 East Main St., Zeeland 49464
Paul D. Croissant, MD, 445 W. Huron St., Pontiac 48053
Louis A. Fabian, MD, 32333 Willoughby Rd., Farmington 48024
Darryl T. Goldberg, MD, 26789 Woodward Ave. #101, Huntington Woods 48070
Charles F. Hartley, MD, 3142 Kingsley Drive, Troy 48084
Dennis W. Harvey, MD, 309 Terrill, Grand Haven 49417
Lawrence D. Hoffman, MD, 27600 Farmington, Farmington 48024

. . . but Doctor, will he represent your interests?

Approximately 2,000 bills of interest to medicine were introduced in the U.S. Congress this year, as were over 150 health bills in the Michigan Legislature.

The responsibility for endorsing, financing and helping to elect wise, dependable political candidates who will listen to the views of the medical profession before voting, rests primarily upon MDPAC and AMPAC.

The MDPAC board is currently assessing the voting record of all legislators and will financially support on a bipartisan basis over sixty candidates for the 1970 legislature. Several members of the Michigan delegation to the Congress have likewise been recipients of MDPAC funds. Much more help is needed. MDPAC has doubled its membership since 1969 and is now approaching 30% of MSMS membership.

MDPAC's effectiveness could develop into a brilliant political success story. It needs your help to accomplish this, and in the 1970 election year a membership of at least a third of Michigan doctors is essential. For twenty-five dollars you can become a member of both AMPAC and MDPAC. MDPAC can only succeed in doing an effective job of campaigning in ratio to the amount of financial help it receives from doctors of medicine.

To every Doctor:

May we urge you to assume your political responsibility as a contributing member of MDPAC-AMPAC. Help us to elect and retain the best men we can get in office both in Lansing and Washington!

The MSMS House of Delegates and The Council endorse, encourage, and strongly recommend that every Michigan doctor of medicine become a member of MDPAC and AMPAC. CONTRIBUTIONS ARE NOT DEDUCTIBLE ON FEDERAL INCOME TAX RETURNS. Please check, if not a member in 1970—We need your help!

Please mail your check for $25.00 today to:

M.D. PAC AMPAC

BOX 769, EAST LANSING, MICHIGAN

special articles

Activities of American Proctologic Society, Founded in 1899, Continue to Expand

The organization and the accomplishments of the American Proctologic Society are detailed in the following article by James A. Ferguson, M.D., Grand Rapids, who is the organization's immediate past president.

By James A. Ferguson, M.D.
Grand Rapids

The American Proctologic Society was founded in 1899 in Columbus, Ohio, at a meeting arranged by a small group of surgeons, which included Joseph Mathews, M.D., who at that time was president of the American Medical Association. Doctor Mathews, who had received special training in rectal surgery in London, England, was, so far as we know, the first person in the world to specialize in this branch of surgery, which is frequently referred to as proctology.

At the meeting in Columbus, he joined with 12 other surgeons to organize the American Proctologic Society and he became its first president. Currently, the Society has almost 850 members, all of whom either limit their practice to this specialty or have a special interest in it.

THE PURPOSES OF the American Proctologic Society are to accumulate and disseminate knowledge and encourage teaching and research pertaining to the colon and rectum. The activities of the Society are designed to carry out these objectives.

The Society arranges an annual meeting, which includes a three or four day scientific program, generally comprised of original papers, panel discussions, and a series of instructional courses on subjects in our specialty. In addition, both scientific and technical product exhibits are an important feature of the meeting.

Almost from its inception, the Society published its proceedings of the annual convention in the form of "Transactions," which contributed significantly to the medical literature in this country. In 1958, replacing "Transactions," the American Proctologic Society founded a new journal, "Diseases of the Colon and Rectum," which is published bi-monthly by J. B. Lippincott Company.

To encourage and support research in colon and rectal diseases, the Society founded the American Proctologic Society Research Foundation in 1957. This is a separate corporation with its own officers and trustees and it provides grants in support of research projects in proctology upon application from any accredited physician in this country.

THE AMERICAN PROCTOLOGIC SOCIETY continually strives to advance the specialty of colon and rectal surgery and one of its first major accomplishments was the formation in 1917 of the Section of Gastroenterology and Proctology of the American

(Continued on Page 800)

PLAINWELL SANITARIUM, INC.

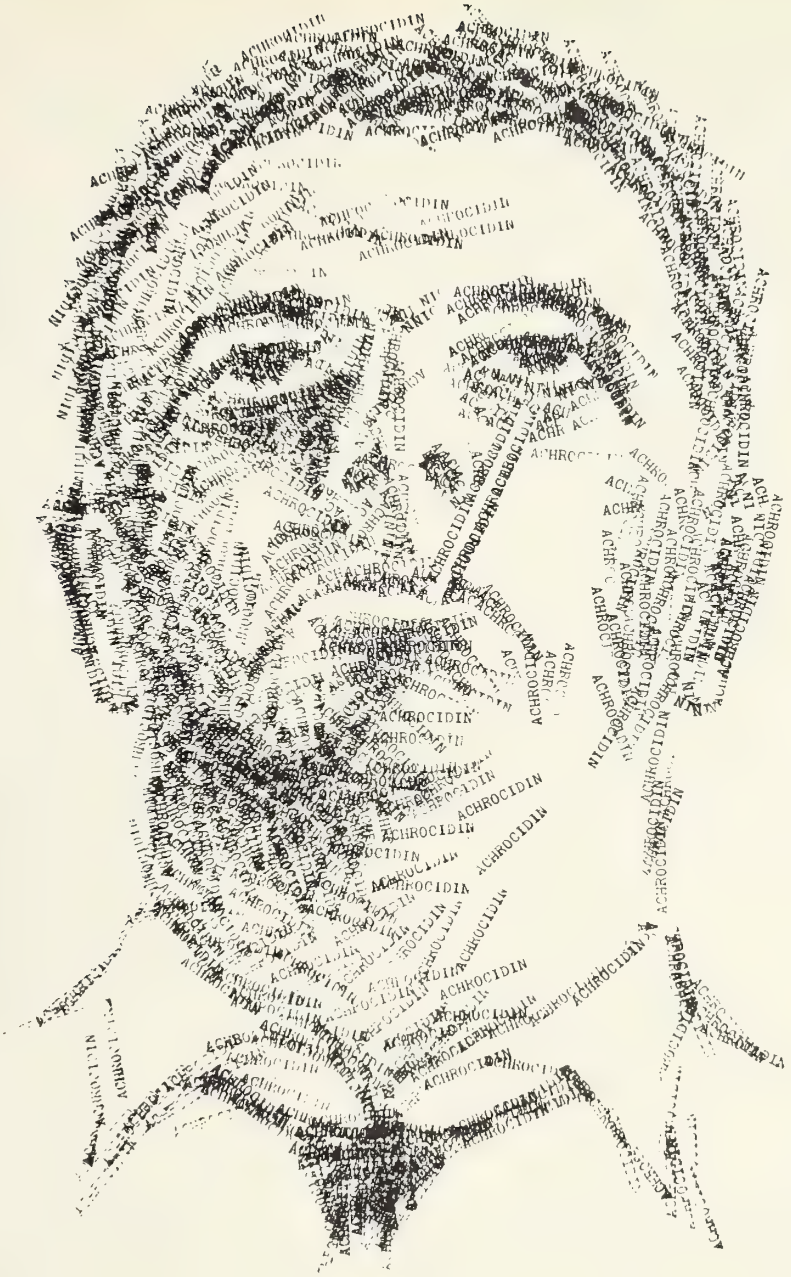
Plainwell, Michigan

M. Leroy Barry, MD
D. W. Everett, MD
W. R. King, PhD

The Plainwell Sanitarium is a private psychiatric hospital licensed by the Michigan Department of Mental Health and accredited by the Joint Commission on Accreditation of Hospitals. Our extensive diagnostic and treatment services include the following:

- Organic and psychological therapy for the psychiatrically and emotionally disturbed of all ages.
- Diagnostic and psychological evaluation and hospitalization, if indicated, of juveniles for courts and social agencies.
- Rehabilitative services for geriatric and convalescent patients.
- Medico-legal counsel.
- Out-patient services.

685-8441 Admissions
685-5952 Out-patients



Achrocidin® Tablets and Syrup

Tetracycline HCl—Antihistamine—Analgesic Compound

Each tablet contains: ACHROMYCIN® Tetracycline HCl 125 mg.; Phenacetin 120 mg.; Caffeine 30 mg.; Salicylamide 150 mg.; Chlorothen Citrate 25 mg.

ACHROCIDIN Tetracycline HCl—Antihistamine—Analgesic Compound Tablets and Syrup are recommended for the treatment of tetracycline-sensitive bacterial infection which may complicate vasomotor rhinitis, sinusitis and other allergic diseases of the upper respiratory tract, and for the concomitant symptomatic relief of headache and nasal congestion. For children and elderly patients you may prefer caffeine-free ACHROCIDIN Syrup. Each 5 cc contains: ACHROMYCIN Tetracycline equivalent to Tetracycline HCl 125 mg.; Phenacetin 120 mg.; Salicylamide 150 mg.; Ascorbic Acid (C) 25 mg.; Pyrilamine Maleate 15 mg.

Contraindications: Hypersensitivity to any component.
Warning: In renal impairment, since liver toxicity is possible, lower doses are indicated; during prolonged therapy consider serum level determinations. Photodynamic reaction to sunlight may occur in hypersensitive persons. Photosensitive individuals should avoid exposure; discontinue treatment if skin discomfort occurs.
Precautions: Drowsiness, anorexia, slight gastric distress can occur. In excessive drowsiness, consider longer dosage intervals. Persons on full dosage should not operate vehicles. Nonsusceptible organisms may overgrow; treat superinfection appropriately. Treat beta-hemolytic streptococcal infections at least 10 days to help prevent rheumatic fever or acute glomerulonephritis. Tetracycline may form a stable calcium complex in bone-forming tissue and may cause dental staining during tooth development (last half of pregnancy, neonatal period, infancy, early childhood).
Adverse Reactions: *Gastrointestinal*—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. *Skin*—maculopapular and erythematous rashes; exfoliative dermatitis; photosensitivity; onycholysis, nail discoloration. *Kidney*—dose-related rise in BUN. *Hypersensitivity reactions*—urticaria, angioneurotic edema, anaphylaxis. *Intracranial*—bulging fontanels in young infants. *Teeth*—yellow-brown staining; enamel hypoplasia. *Blood*—anemia, thrombocytopenic purpura, neutropenia, eosinophilia. *Liver*—cholestasis at high dosage.
Upon adverse reaction, stop medication and treat appropriately.

Lederle LEDERLE LABORATORIES, A Division of American Cyanamid Company, Pearl River, New York 10965

535-9

Medical Association. Subsequently, these two specialties were separated so that there is now a Section of Colon and Rectal Surgery in the AMA.

The Society also assumed a major role in the formation of the American Board of Colon and Rectal Surgery, for the purpose of qualifying men in the specialty. When first organized, this Board was an affiliate of the American Board of Surgery and it remained so until 1949, when it became an independent Board. The present Board of Colon and Rectal Surgery is one of 18 recognized specialty Boards organized for the purpose of qualifying specialists, and our Society is represented on this Board.

The Society is also privileged to have representation in the American College of Surgeons, both on their Board of Governors and on the Advisory Council for Proctology.

Of primary concern to the Society is the education and training of men in colon and rectal surgery. The Society has for several years maintained a special Loan Fund to which residents may apply for assistance to enable them to complete their training. In addition, present efforts are being directed toward increasing the number of approved residency programs in order to increase the number of qualified specialists in Colon and Rectal Surgery.

Doctor Block Invites Interested Physicians To Join Industrial Medical Association

Doctor Block, who is immediate past president of the Industrial Medical Association, describes the purposes and advantages of membership in the IMA. Doctor Block is new medical director of the Ford Motor Company.

By Duane L. Block, M.D.
Dearborn

The Industrial Medical Association, founded in 1916, is an international professional society of approximately 4,000 Doctors of Medicine practicing that branch of medicine called Industrial or Occupational Medicine.

The stated purposes and objectives of the Association are:

1. To foster the study of problems peculiar to the practice of industrial medicine and surgery.
2. To unite into one organization members of the medical profession whose interests lie in that field and assert their identification with it.
3. To encourage and foster the development of methods adaptable to the conservation and improvement of health among workers.
4. To promote a more general understanding of the purposes and the results of the medical care and health maintenance of these workers.

The Association has 29 component societies in the United States. They constitute the regional chapters of the Association. Each component society elects its own officers and directors, elects its own delegates to the parent Association's House of Delegates, and holds its own scientific meetings periodically.

PROFESSIONAL EDUCATION is a major activity of the Industrial Medical Association. Scientific committees develop official statements of policy and philosophy based on research and investigations of various aspects of occupational medical practice. Each Spring the Association holds its annual scientific and business meeting concurrently with the American Association of Industrial Nurses. This combined meeting, known as the American Industrial Health Conference, provides an excellent opportunity for professional discussion on matters of concern in the field of occupational medicine. The meeting features presentation of scientific papers, panel discussions, symposia and intensive postgraduate seminars.

The *Journal of Occupational Medicine,* the foremost journal in this field, is owned and published by the Industrial Medical Association. Through this monthly journal the membership of the association is kept informed of developments, trends and current thinking in this broad and challenging field. The Occupational Health Institute is an educational non-profit organization created by the Industrial Medical Association to promote graduate education in occupational health, sponsor regional intensive educational courses and to assist industry in the formulation,

MICHIGAN MEDICINE ON MICROFILM

Microfilmed copies of current as well as all back issues of *Michigan Medicine* are available through University Microfilm Services, a subsidiary of Xerox Corporation. The 35 mm film fits all standard viewers and provides the JOURNAL in miniature at a savings on binding and storage costs. Write for information or send orders direct to University Microfilm Services, 300 North Zeeb Road, Ann Arbor, Michigan 48106.

The venerable Sheraton-Cadillac Hotel on Washington Boulevard in downtown Detroit, the city's largest hotel, will host the 1970 MSMS Annual Session. The convention commences Sept. 20 with three days of meetings by the MSMS House of Delegates, and concludes Sept. 23 and 24 with the stimulating and informational Scientific Sessions, featuring outstanding medical authorities from many fields.

development and certification of occupational health programs.

The Association maintains liaison relationships with many other professional organizations. Recognizing, however, that medical care for a majority of employes in the work force is provided by private practitioners of medicine, the Association has been constantly exploring methods by which improved communication may be developed between the Industrial Medical Association and the private practitioner.

The advantages of membership in the IMA are numerous. I invite physicians who have interest in the field of Industrial or Occupational Medicine to consider membership in our Association.

Aid to Med Students One of Auxiliary's Finest Services

By Mrs. Edward Maxim
President
Woman's Auxiliary to MSMS

The only official fund raising project of the Woman's Auxiliary to the American Medical Association and the Woman's Auxiliary to the Michigan State Medical Society is that of raising funds for the American Medical Association Education and Research Foundation (AMA-ERF).

With the closing of the Institute of Bio-Medical Research on July 1, we now support only two AMA-ERF programs.

They are (1) *Funds for Medical schools,* used by medical school deans to help pay faculty salaries; purchase library books, modern equipment and expansion programs; and solve other financial problems for which budgeted funds are not available, and (2) *Student Loan Guarantee Fund,* helping needy students meet the staggering financial cost of their medical education. Each dollar in the fund puts another $12.50 to work in loans made by a commercial bank. As the money is paid back it is then available to loan out again.

Funds are desperately needed to accelerate medical school programs and provide a source of financial aid for the medical student (in school or residency).

In my inaugural address last September, I listed AMA-ERF as one of our prime concerns. Our State AMA-ERF Chairman Mrs. Dean Carron and 34 county chairmen took up the challenge. This year the auxiliaries of Michigan raised $28,265.51 (a 25.89% increase over last year's giving).

It was indeed a proud moment for me at the National Auxiliary Convention to accept for the state of Michigan a National Award of Merit for having the highest per capita giving of any state in the North Central Region. We were the state with the highest per capita giving in the nation of those states with a membership of 2,000 or more members. It was also my privilege to accept for my home county of Macomb, a National Award of Merit for the highest per capita giving in the category of 61-100 members.

These monies collected mean an untold number of hours of dedicated work by Auxilians. The ways of raising funds are many. They range from Christmas Card exchanges, auction sales, fashion shows, merchandise sales and the many generous gifts by physicians to their alumni associations through the Auxiliary Fund. About 40% of the money to AMA-ERF comes as direct contributions.

Many times I am asked what the Auxiliary does. This year I can say one of our finest contributions to helping organized medicine has been to help finance some of the needs of medical schools and some of the students in need.

22 Berrien Physicians Providing Health Care To Migrant Families

The excellent record of Berrien County physicians in providing family health care to the influx of migrant workers during the summer has been the subject of comment by the U. S. Public Health Service.

In a letter sent to Robert Locey, M.D., originator in 1966 of the unique arrangement of Migrant Health Clinics in Southwestern Michigan, Eugene W. Veverka, M.D., acting director of the Division of Health Care Services, said, "Berrien County has, for many years, served as a model for the provision of migrant family health services. . . Were it not for the concern of the physicians in southwest Michigan for providing health services to migrant families, it would indeed be difficult to mobilize the concerted effort necessary to the delivery of quality medicine."

There are 22 M.D.s and four D.O.s working in the clinics this summer, with help from the Kalamazoo Physicians' Emergency Services, P. C. and 10 students from the University of Chicago Medical School who are spending one month each at Lee Memorial Hospital, Dowagiac, to learn rural medicine.

The clinics, open from June 8 to Sept. 4, are staffed by three physicians at a time and are open Monday through Friday evenings in Berrien Springs and each week night except Thursday in the community of Keeler.

The clinics also provide dental care, health education, environmental sanitation, nursing field visits and in-patient medical care.

WCMS Board Officers Named

New officers of the Wayne County Medical Society's Board of Trustees are F. P. Rhoades, M.D., chairman; Sidney Adler, M.D., treasurer, and Frank Bicknell, M.D., House chairman.

St. Clair Physicians Honor Local Workers In Rubella Campaign

The St. Clair County Medical Society, in cooperation with the St. Clair County Health Department, presented a certificate of commendation recently to the County Chapter, National Foundation-March of Dimes, for the chapter's efforts in the 1969 rubella immunization campaign. The presentation was made by SCCMS President Sidney C. Walker, M.D.

Involvement the Key To County Medical Society, Writes Oakland Physician

Thomas D. Tierney, M.D., Birmingham, wrote proudly of his county medical society in the July *Bulletin* of the Oakland County Medical Society. "The Oakland County Medical Society has consistently been one of Michigan's more active county medical groups," he said.

But he could have been speaking for all county medical society members when he said, "Physicians have many specific desires and feelings which they want presented," he continued. "Involvement is required in order to have one's views represented. Involvement can be extensive or short and sweet; but it is all very important. Involvement makes the world go around. Involvement makes the (Oakland) County Medical Society. The (Oakland) County Medical Society helps make you."

Lenawee Society Program Leads to Another Crisis Answering Service

A talk before the Lenawee County Medical Society last spring by Det. David Snyder of the Lenawee County Sheriff's Department was the catalyst in the development of another crisis telephone answering service in Michigan.

Patricia Wentz, M.D., Adrian, was at the meeting. She had felt the need for some time for such a service for persons in need of help. After hearing Det. Snyder talk, she formed a group of Adrian professional people from various fields under the name, "Call Someone Concerned."

"Call Someone Concerned" is basically an informational service, to refer those in need of help to the best source of aid. It is hoped by Doctor Wentz and her organization that the service may lead to a walk-in clinic. They also plan to establish a system of once-a-day calls to elderly people living alone.

SANDOZ Sandoz announces...

a new agent for the alcohol-dependent patient who wants to quit

and

a program for the Michigan physician who wants to help

When alcohol becomes a way of life
new SERENTIL® (mesoridazine

a major tranquilizer with specific advantages for the alcohol-dependent patien

1. Alleviates tension, anxiety, and depression; may also ease prevalent neurotic symptoms in personality disorders.
2. No reported habituation or addiction.
3. Antiemetic properties to control nausea and vomiting.
4. Has not caused hepatic dysfunctio or interfered with functional reco ery of impaired liver.
5. Four tablet strengths to allow flexib ity of dosage (usual starting dos for the problem drinker, 10 mg. t.i.d for the frank alcoholic, 25 mg. b.i.d
6. Injectable form available for acut episodes.

rogram for early recognition and successful treatment:

Alcoholism in Michigan*

	State Rank	
otal no. alcoholics	6th	
o. per capita	11th	
er capita consumption†	15th	
Michigan Physicians' Report (compared with U.S. average)	%Mich.	%U.S.
ee 5 or more problem rinkers in 2-month period	44.4	37.1
alf or more seen are women	29.9	37.4
reat, rather than refer	68.8	72.6
ore community services eeded	63.1	63.0

based on preliminary data supplied by Center of lcohol Studies, Rutgers Univ. †absolute alcohol

The Ins-and-Outs of Alcoholism: A series of recordings and other mailings, each concerned with a particular aspect of the alcohol problem. Recognized authorities in the field discuss the scope, recognition and treatment of alcohol-dependent patients. Also included will be **The Alcoholic Directory**, a nationwide survey of treatment centers.

Interested? Complete and mail this coupon to:

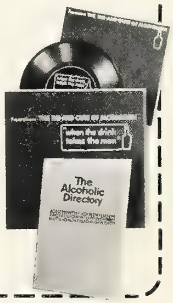
Dept. SERENTIL/Sandoz Pharmaceuticals
Route 10/Hanover, N. J. 07936

SANDOZ

Dr. ____________________
(PLEASE PRINT)

Street ____________________

City __________ State __________ Zip __________



See next page for prescribing information.

INDICATIONS: In clinical studies, Serentil (mesoridazine) has been found useful in the following disease states

Alcoholism—Acute and Chronic: Serentil ameliorates anxiety, tension, depression, nausea and vomiting in both acute and chronic alcoholics without producing hepatic dysfunction or hindering the functional recovery of the impaired liver.

Schizophrenia: Serentil is effective in the treatment of schizophrenia. It substantially reduces the severity of Emotional Withdrawal, Conceptual Disorganization, Anxiety, Tension, Hallucinatory Behavior, Suspiciousness and Blunted Affect in schizophrenic patients. As with other phenothiazines, patients refractory to previous medication may respond to Serentil.

Behavioral Problems in Mental Deficiency and Chronic Brain Syndrome: The effect of Serentil was found to be excellent or good in the management of hyperactivity and uncooperativeness associated with Mental Deficiency and Chronic Brain Syndrome.

Psychoneurotic Manifestations: Serentil reduces the symptoms of anxiety and tension, prevalent symptoms often associated with neurotic components of many disorders, and benefits personality disorders in general.

CONTRAINDICATIONS: As with other phenothiazines Serentil (mesoridazine) is contraindicated in severe central nervous system depression or comatose states from any cause. Serentil is contraindicated in individuals who have previously shown hypersensitivity to the drug.

WARNINGS: Where patients are participating in activities requiring complete mental alertness (e.g., driving), it is advisable to administer the phenothiazines cautiously and to increase the dosage gradually.

Usage in pregnancy: The safety of this drug in pregnancy has not been established; hence, it should be given only when the anticipated benefits to be derived from treatment exceed the possible risks to mother and fetus.

Usage in children: The use of Serentil in children under 12 years of age is not recommended, because safe conditions for its use have not been established.

Attention should be paid to the fact that phenothiazines are capable of potentiating central nervous system depressants (e.g., anesthetics, opiates, alcohol, etc.) as well as atropine and phosphorus insecticides.

PRECAUTIONS: While ocular changes have not to date been related to Serentil, one should be aware that such changes have been seen with other drugs of this class.

Because of possible hypotensive effects, reserve parenteral administration for bedfast patients or for acute ambulatory cases, and keep patient lying down for at least ½ hour after injection.

Leukopenia and/or agranulocytosis have been attributed to phenothiazine therapy. A single case of transient granulocytopenia has been associated with Serentil (mesoridazine).

ADVERSE REACTIONS: Drowsiness and hypotension were the most prevalent side effects encountered. Side effects tended to reach their maximum level of severity early with the exception of a few

SERENTIL®
(mesoridazine)
new weapon
in the fight against
alcoholism

(rigidity and motoric effects) which occurred later in therapy.

With the exceptions of tremor and rigidity, adverse reactions were generally found among those patients who received relatively high doses early in treatment. Clinical data showed no tendency for the investigators to terminate treatment because of side effects.

Serentil has demonstrated a remarkably low incidence of adverse reactions when compared with other phenothiazine compounds.

Central Nervous System: Drowsiness, Parkinson's syndrome, dizziness, weakness, tremor, restlessness, ataxia, dystonia, rigidity, slurring, akathisia, motoric reactions (opisthotonos) have been reported.

Autonomic Nervous System: Dry mouth, nausea and vomiting, fainting, stuffy nose, photophobia, constipation and blurred vision have occurred in some instances.

Endocrine System: Inhibition of ejaculation and lactation have been noted rarely.

Skin: Itching, rash, hypertrophic papillae of the tongue and angioneurotic edema have been reported.

Cardiovascular System: Hypotension and tachycardia have been reported. EKG changes have occurred in some instances (see Phenothiazine Derivatives: Cardiovascular Effects).

Phenothiazine Derivatives: It should be noted that efficacy, indications and untoward effects have varied with the different phenothiazines. The physician should be aware that the following have occurred with one or more phenothiazines and should be considered whenever one of these drugs is used:

Autonomic Reactions: Miosis, obstipation, anorexia, paralytic ileus.

Cutaneous Reactions: Erythema, exfoliative dermatitis, contact dermatitis.

Blood Dyscrasias: Agranulocytosis, leukopenia, eosinophilia, thrombocytopenia, anemia, aplastic anemia, pancytopenia.

Allergic Reactions: Fever, laryngeal edema, angioneurotic edema, asthma.

Hepatotoxicity: Jaundice, biliary stasis.

Cardiovascular Effects: Changes in the terminal portion of the electrocardiogram, including prolongation of the Q-T interval, lowering and inversion of the T-wave and appearance of a wave tentatively identified as a bifid T or a U wave have been observed in some patients receiving the phenothiazine tranquilizers, including Serentil (mesoridazine). To date, these appear to be due to altered repolarization and not related to myocardial damage. They appear to be reversible.

There is no evidence at present that these chan
are in any way precursors of any significant
turbance of cardiac rhythm.

Hypotension, rarely resulting in cardiac arr
has been noted.

Extrapyramidal Symptoms: Akathisia, agitat
motor restlessness, dystonic reactions, tris
torticollis, opisthotonos, oculogyric crises, tre
muscular rigidity, akinesia—some of which
rare occasions have persisted for several mo
or years especially in patients of advanced
with brain damage.

Endocrine Disturbances: Menstrual irregulari
altered libido, gynecomastia, weight gain. F
positive pregnancy tests have been reported.

Urinary Disturbances: Retention, incontinence.

Others: Hyperpyrexia. Behavioral effects sug
tive of a paradoxical reaction have been repor
These include excitement, bizarre dreams, ag
vation of psychoses and toxic confusional st
More recently, a peculiar skin-eye syndrome
been recognized as a side effect following l
term treatment with phenothiazines. This reac
is marked by progressive pigmentation of ar
of the skin or conjunctiva and/or accompanied
discoloration of the exposed sclera and cor
Opacities of the anterior lens and cornea
scribed as irregular or stellate in shape h
also been reported.

DOSAGE AND ADMINISTRATION: Oral: The
age of Serentil (mesoridazine), as in most m
cations, should be adjusted to the needs of
individual. The lowest effective dosage sh
always be used. When maximum response
achieved, dosage may be reduced gradually
a maintenance level.

Alcoholism: For most patients the usual star
dose is 25 mg. b.i.d. The usual optimum t
daily dose range is 50-200 mg. per day.

Schizophrenia: For most patients, regardless
severity, a starting dose of 50 mg. t.i.d. is re
mended. The usual optimum total daily dose ra
is 100-400 mg. per day.

Behavioral Problems in Mental Deficiency
Chronic Brain Syndrome: For most patients a s
ing dose of 25 mg. t.i.d. is recommended.
usual optimum total daily dose range is 75-300
per day.

Psychoneurotic Manifestations: For most patient
usual starting dose is 10 mg. t.i.d. The usual
mum total daily dose range is 30-150 mg. per

Injectable Form: In those situations in which
intramuscular form of medication is indic
Serentil (mesoridazine) Injectable is available.
most patients a starting dose of 25 mg. is re
mended. The dose may be repeated in 30 t
minutes, if necessary. The usual optimum total
dose range is 25-200 mg. per day.

HOW SUPPLIED: Tablets: 10 mg., 25 mg., 50
and 100 mg. mesoridazine (as the besylate).
tles of 100.

Ampuls: 1 cc. [25 mg. mesoridazine (as the b
ate)]. Inactive ingredients—Disodium Ede
U.S.P., 0.5 mg.; Sodium Chloride, U.S.P., 7.2
Carbon Dioxide Gas (Bone Dry), q.s.; Wate
Injection, U.S.P., q.s. to 1 cc. Boxes of 20 and
SER70-1

Sandoz Pharmaceuticals, Hanover, N.J.

What the doctors in this country need is a simple, accurate lab system for under $600.

That's why we invented the UNITEST SYSTEM.

hysicians can't operate their offices ke doctors did in the old days.

That's when the patient load was ɔwer and so was the overhead, in ase you wanted to have lab tests erformed right on the premises. here were a lot more qualified technicians for hire, too. Or if you didn't ant the bother and payroll of a bigger staff, you sent specimens out to local lab or a nearby hospital. Then ou waited for results to return and dded the charge to the bill.

Problem is, that way isn't economically feasible any longer. More sohisticated lab tests have been deeloped to aid your diagnosis. Fewer killed personnel are available. The omplex equipment required is more xpensive. And the cost of space is remium.

Somebody had to solve this kingzed problem. We did.

Bio-Dynamics, Inc.
The Simplifiers

9115 Hague Road
Indianapolis, Indiana 46250

We perfected the compact UNITEST SYSTEM. You start with the heart and brains, the Unimeter. It sells for below $600. Far below, in fact. Then, you add-on components you don't already own. When you're done, any qualified person in your office can run 14 tests for the most commonly-needed determinations. That includes Blood Glucose, Hemoglobin, B.U.N., Uric Acid and Cholesterol.

And you get accurate test results faster, often before the patient leaves.

Yes, the compact UNITEST SYSTEM is a lot smaller than you'd expect for equipment that does so much. And there are so many functions it does so well, you really owe it to yourself to get more information. Some is on the following page. The card below will bring you all of it. Just complete, detach and mail.

Gentlemen:

I am interested in receiving more information about use of the UNITEST SYSTEM in my office.

Name ______________________________

Address ______________________________

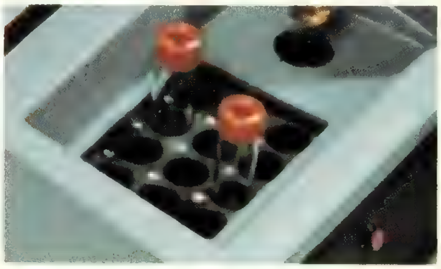
City ______________ State ______________ Zip ______________

Phone No. ______________________________

The UNITEST SYSTEM provides these important features:

The Unimeter—The Unimeter 250 is a precisely-calibrated, solid state colorimeter. Rugged in design and simple to operate, it has only three controls: on-off switch, calibration control dial and temperature control button.

The Select-a-Fuge 24 — The most advanced centrifuge in its category ever developed . . . a single unit capable of performing *three* centrifugated preparations where at least two units were previously required . . . and in the shortest possible time for each specimen involved. The Select-a-Fuge 24 can prepare urine specimens at the low speed of 4000 rpm . . . or perform uniformly consistent serum, plasma and hematocrit results at 10,000 rpm. Other preparations requiring graduating intermediate speeds may also be conducted. Select-a-Fuge 24 does all this without changing equipment, without adding or removing parts.



Built-in Incubator — The Unimeter has a convenient built-in incubator which holds twelve tubes at a constant temperature of 37°C. There is an instant push-button temperature check.

UNIMETER 250

Interchangeable Meter Faces—The slip-in meter face cards with color-coded test scales allow the operator to adapt this unit to a variety of tests and to incorporate any new tests which may be added in the future.

Push Button Pipetting—Automati Pipette controls critical measurements precisely with remarkabl ease and speed. Assures dependable results between operators, regardless of their individual skills.

Unitube—The optically correct glass Unitube contains reagent materials. It also contains the reactio and is used as a cuvette, when th reaction is complete. After the resu is recorded the Unitube is discarde Unitube caps are color-coded fc each test.

BLOOD GLUCOSE TEST

Unitest Kits — Each kit contain everything necessary to perform th tests. Everything is pre-measure color-coded, sealed against contamination and disposable. Simpl step-by-step illustrated instruction are enclosed in every kit. Kits ar available in a variety of sizes.

For full details,
mail this card today!

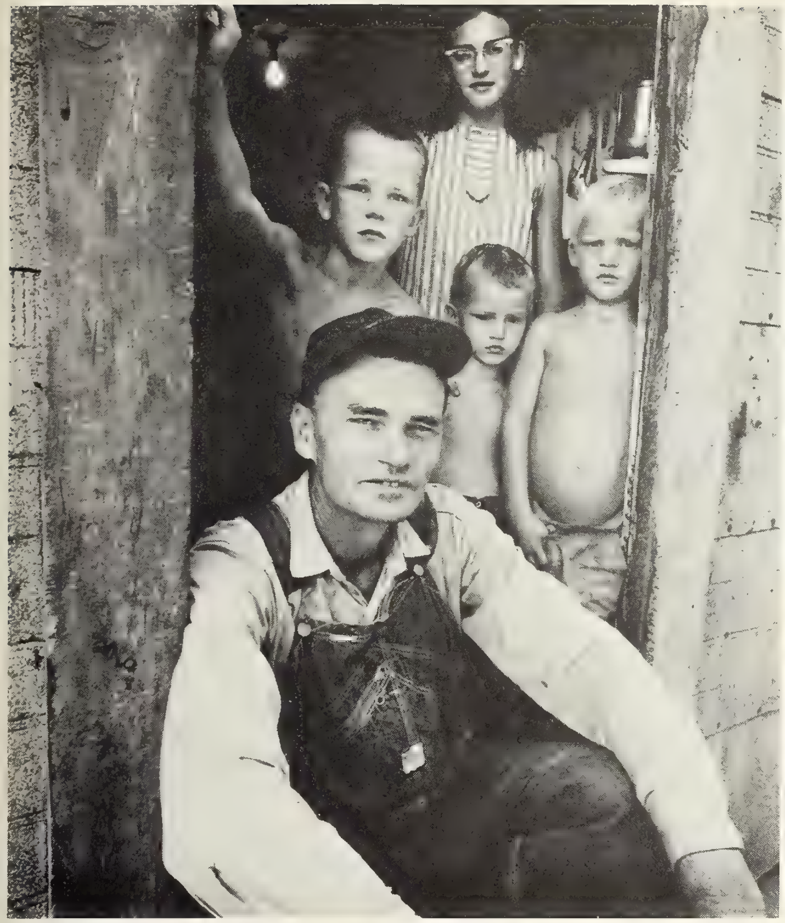
Bio-Dynamics, Inc.
The Simplifiers

First Class
Permit No. 4810
Indianapolis, Ind.

BUSINESS REPLY MAIL
No postage necessary if mailed in the United States

Postage will be paid by

Bio-Dynamics, Inc.
Box 50100
Indianapolis, Indiana 46250



80 Michigan Doctors Working to Aid Impoverished Fayette, Miss.

By Judith Marr
Managing Editor

The desire of one Flint physician to aid the causes of peaceful integration of the races, eradication of poverty and better education of doctors has become the project of nearly 80 Flint and Grand Rapids M.D.s.

E. Marshall Goldberg, M.D., director of medical education at Flint's Hurley Hospital, saw Fayette, Miss., as most in need of his fellow physicians' help.

"First, it has only one overworked general practitioner to serve a population of 10,000 people," he explained. "Second, its mayor, Mr. Charles Evers, is one of our nation's most eloquent and effective civil rights leaders and a man who aspires to help the people of his community through reason, not violence."

Last, Doctor Goldberg thought, the experience of practicing medicine in Fayette "might do wonders for the young house staff by weaning them away from their dependence on the X-ray machine and the lab and forcing them to develop their skills in questioning and examining a patient before reaching a diagnosis."

The young, curly-haired Doctor Goldberg is aware of the criticism aimed at the medical profession by its youngest members — "that doctors do very little charity medicine anymore and that they have promulgated an outdated, ineffective system of health care that falls far short of meeting the needs of the disadvantaged and poor."

Therefore he proposed sending three-man teams of physicians — two house staff and one attending man — to Fayette every two weeks, "and, hopefully, to provide better health care for the people of Jefferson County."

He convinced his Hurley Hospital colleagues so well that 80 per cent of the house staff volunteered to go. The Butterworth Hospital attending and house staffs of Grand Rapids also joined in.

Doctor Goldberg won sanction of the project from the Mississippi State Board of Registration in Medicine and the Mississippi State Medical Society. The staffs of the Flint hospitals and the Genesee County Medical Society approved the project in principle and the Hurley Hospital Board of Managers permitted the physicians to make two weeks in Fayette part of their training curriculum.

Doctor Goldberg led the first team to Fayette on June 1.

"We did all sorts of things — surgery and general medicine," he reported on his return. "We saw 30-50 patients each day. They were very grateful and the physicians we worked with were quite cordial."

For the first time, the Fayette medical community is giving 24-hour service to the community, says Doctor Goldberg. He is also pleased to point out that this is the first time staff members of a community hospital have carried out such a project without the support of either the government or a medical school.

Three teams from Hurley went to Fayette in June. In July, similar teams from Butterworth Hospital in Grand Rapids took over the project, with Hurley staff again in charge in August.

Doctor Goldberg and co-chairman E. L. Moorhead, M.D., Grand Rapids, plan to send a total of 78 physicians from both towns to Fayette this year and possibly next.

"But we see this as a self-limiting project," says Doctor Goldberg, for HEW has granted funds to Fayette for the building of a Comprehensive Health Center, which, when completed, will relieve the Michigan physician teams of their responsibility.

Photos Courtesy "Sources, 1968" Blue Cross Assoc

A smaller, separate clinic, expected to be completed this month, is being built for the northern doctors with a grant from the Medgar Evers Foundation. Drug companies have donated $90,000 worth of pharmaceuticals for the project and a Flint philanthropist has provided the funds for transportation to and from Mississippi.

Fayette is located in Jefferson County, which, according to Doctor Goldberg, has less than a thousand of its inhabitants eligible for assistance through Medicare and Medicaid, though 80 per cent of them are jobless and on welfare, and their average income is no more than $800 per year.

Says Doctor Goldberg, "Perhaps our example might encourage medical groups in other communities to follow our lead."

The Doctor's Income Tax Calendar

Sept. 15 — Pay the third installment of your 1970 Federal tax. (One-fourth of your estimated income tax and one-fourth of your Social Security tax of $538.20). If your contributions to your employes' Social Security plus the Social Security and income taxes withheld from their salaries exceeded $100 in August, complete Form 501 and pay the taxes.

Oct. 15 — If your contributions to your employes' Social Security plus the Social Security and income taxes withheld from their salaries exceeded $100 in September, complete Form 501 and pay the taxes.

Nov. 2 — Pay the balance of your third-quarter contributions to your employes' Social Security, plus the Social Security and income taxes withheld from their salaries from July 1 through Sept. 30; file Form 941. If the taxes exceeded $2,500 in any month of the preceding quarter, you must now remit semimonthly.

Nov. 16 — If your contributions to your employes' Social Security plus the Social Security and income taxes withheld from their salaries exceeded $100 in October, complete Form 501 and pay the taxes.

Dec. 1 — Meet with tax adviser to plan year-end tax strategy to take advantage of any 1971 rate cuts.

Dec. 15 — If your contributions to your employes' Social Security plus the Social Security and income taxes withheld from their salaries exceeded $100 in November, complete Form 501 and pay the taxes.

BRIGHTON HOSPITAL

A non-profit foundation
FOR ALCOHOLISM
Member, Michigan Hospital Association, American Hospital Association

A facility designed to rehabilitate and aid the compulsive drinker in arresting his addiction.

Brighton Hospital meets the standards established by the Michigan State Board of Alcoholism and is recommended by that Board.

12851 East Grand River
One block south of I-96 at Kensington Rd. Exit
four miles east of U.S. 23
Brighton, Michigan
ACademy 7-1211

(A 16-m.m. sound color film on Brighton Hospital is available for free loan to qualified groups.)

Specialized ★ Service
IN
PROFESSIONAL LIABILITY INSURANCE
is a high mark of distinction
THE
MEDICAL PROTECTIVE COMPANY
FORT WAYNE, INDIANA
Professional Protection Exclusively since 1899

DETROIT OFFICE: R. K. Wind and J. K. Galloway, Representatives
27200 Lahser Road, Southfield 48075, Telephone: (Area Code 313) ELgin 3-4848 or 444-1439

GRAND RAPIDS OFFICE: G. J. Haworth, Representative
422 Federal Square Building, Grand Rapids 49502 Telephone: 616-454-4477

ancillary

Toward Improved Health Care: *A Consumer's View*

By Emil Mazey
Secretary-Treasurer, UAW

The UAW has long sought to negotiate better health care for our members. Over the vigorous opposition of auto management in the early 1940's, we successfully bargained for the right of our members to pay their own group Blue Cross-Blue Shield premiums. Today, most of our members are covered by the best available group health insurance or prepaid group health care programs.

Our Union is not a narrow selfish pressure group. We are vitally concerned with the total health of the nation. We worked hard to secure the adoption of Medicare and continue to seek its improvement.

We realize, however, that Medicare is, at best, a limited financial answer to our nation's growing health care crisis. If America fails to improve the overall structure for the financing and delivery of health care, consumers will pump ever-increasing billions of dollars into subsidizing the waste and obsolescence presently built into our health care non-system.

American Health Care Has Failed

America has the greatest health technology in the world. But nowhere, however, is the gap between promise and performance wider. National life expectancy, mortality and morbidity indicators confirm this conclusion.

The health insurance industry, which organized labor has supported, plainly has failed to meet the health needs of our nation. It provides sickness insurance, not health insurance. It has failed to provide comprehensive benefits or to control costs or assure quality. It provides practically no preventive health services and has failed almost completely to make health services available to the poor and the medically indigent.

Available data clearly indicate that we are not receiving anywhere near our health care money's worth. Health care costs have increased at a rate almost twice that of the overall cost-of-living—which itself has increased far too rapidly. Health care costs will continue to increase disproportionately unless America acts now to meet the growing health care crisis.

Steps To Improve Health Care

We believe that the team approach to health care is basic to improving the quality of care and controlling needless costs. Members of prepaid comprehensive health care plans, such as Community Health Association (CHA), and Kaiser have clearly demonstrated that as compared with solo practitioners, prepaid group medical plans can provide good quality care at far lower cost to the patient.

In Michigan, in each of the last three years, CHA members used approximately half as many hospital days per 1,000 members as patients who received their care under Blue Cross-Blue Shield fee-for-service medical programs. One reason for this tremendous saving is the emphasis CHA and other prepaid group practice plans place on keeping the patient well by use of preventive services, early diagnosis and treatment outside the hospital.

Group practice is an important component of the comprehensive national health insurance plan

(Continued on Page 815)

This article is based on remarks before Mid-West Health Congress, March, 1970.

Remember how great milk of magnesia tasted?

Almost as good as castor oil.

But now you can spare the taste buds and spoil the patient with a modern Dulcolax tablet or suppository.

And Dulcolax works so predictably that the time of bowel movement can often be predicted. Tablets taken at night usually produce a bowel movement the following morning. Suppositories generally work in 15 minutes to an hour.

For preoperative preparation, a combination of tablets at night and a suppository the next morning usually cleans the bowel thoroughly.

Dulcolax suppositories may be particularly helpful when straining should be avoided, as in postoperative care. Keep in mind, however, that the drug is contraindicated in the acute surgical abdomen.

Dulcolax®...it's predictable
bisacodyl

license from Boehringer Ingelheim G.m.b.H. Geigy Pharmaceuticals, Division of Geigy Chemical Corporation, Ardsley, New York 10502 DU-7015

“What she really needs, Doctor, is a shot of penicillin

Maybe. Maybe not. In any case she needs something to control her sneezing, watery eyes and runny nose. And for most children over six, Novahistine® LP can be depended on to provide fast relief from summer colds and allergy. These continuous-release tablets have a vasoconstrictor-antihistamine formulation that begins working in minutes, then continues to provide relief for hours. A single Novahistine LP tablet, morning and evening, can keep most young patients free of symptoms all day and all night. Us with caution in individuals with severe hypertension, diabetes mellitus, hyperthyroidism or urinary retention. Caution ambulatory patients that drowsiness may result.

Novahistine
LP decongestant

(Each tablet contains 25 mg. of phenylephri hydrochloride and 4 mg. of chlorpheniram maleate.)

DOW THE DOW CHEMICAL COMPANY Rx Pharmaceuticals Indianapolis

Medical Assistants Offer Educational Aids

The Michigan State Medical Assistants Society, represented here by Mrs. Patricia Austin, Ann Arbor, right, MSMAS president, and Mrs. Jacqueline VanDeventer, MSMS coordinator of women's activities, is making available to interested persons a series of publications on the career of the medical assistant and the purposes of the medical assistants' society. They are available to interested physicians on request from Mrs. VanDeventer at MSMS Headquarters, and have been mailed in packets to each county medical assistant society in Michigan. Mrs. VanDeventer and Mrs. Austin remind Michigan physicians of the importance of the educational effort through the words of Milford O. Rouse, M.D., when he was president of the AMA: "I believe every physician should encourage his assistants to become active members of their local societies and to participate in efforts to upgrade the standards of the members."

IN FRONT OF EVERY
GOOD M.D. THERE'S A
GOOD M.A.!
KEEP IN STEP
AAMA

Toward Improved Health Care

(Concluded from Page 812)

just announced by the Committee of 100 for National Health Insurance (CNHI). The UAW has supported the efforts of the Committee because of our belief in our nation's responsibility to assure quality total health care for every citizen, regardless of economic status. As one means to this end, the Committee has made major recommendations to support and upgrade the nation's institutional facilities and the expanded training of professional and ancillary health personnel.

The proposed plan will be financed by contributions from employers, employees; the self-employed and from Federal general tax revenues. Benefits will be comprehensive. The plan also includes provisions designed to safeguard the quantity, quality, effectiveness, continuity and economy of the family health care services it finances. Through financial incentives, better organization, coordination and built-in cost controls and standards, we expect to avoid the costly waste which presently plagues health care in America.

Members of CNHI and the UAW are convinced that our new program will establish a uniquely American system of national health insurance. The system will use financial leverage to extend and improve the best features of some of our current means of providing service. It will avoid, however, the present non-system's built-in waste, duplication and inefficiencies.

Daniel P. Moynihan To Speak in November At U-M Drug Symposium

A faculty of outstanding scholars from around the world will lead the International Drug Symposium for physicians being planned Nov. 9-13 at the University of Michigan Towsley Center for Continuing Medical Education.

Chris J. D. Zarafonetis, M.D., U-M professor of internal medicine, is chairman of the planning committee for the event. It will include a discussion of the sociologic milieu as it relates to drug abuse, by Daniel P. Moynihan, counsellor to President Richard Nixon.

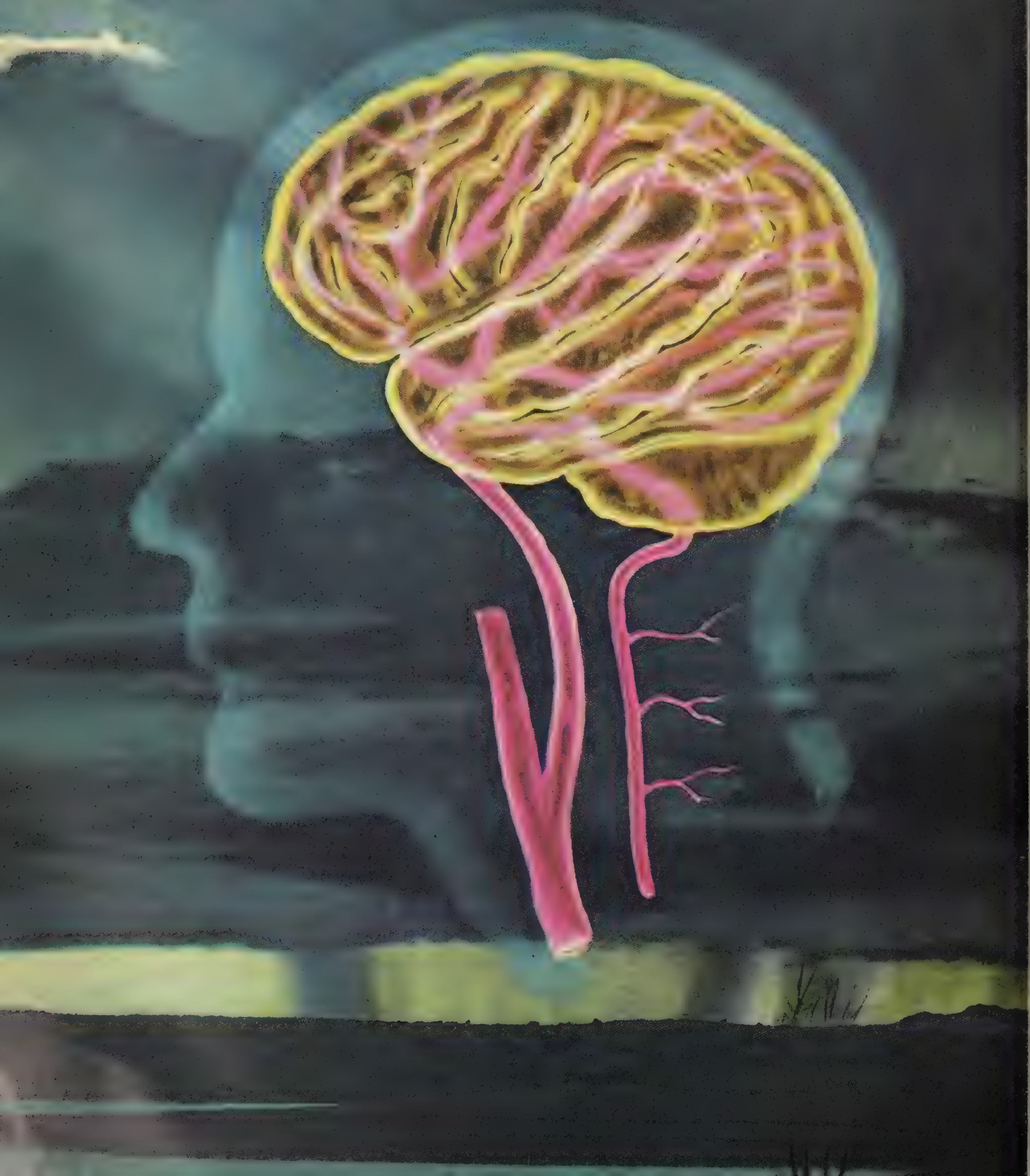
Speakers at the symposium from foreign countries will include Thomas Bewley, M.D., Tooting Bec Hospital, London; Dale Cameron, M.D., World Health Organization, Switzerland; Leonard Goldberg, M.D., Karolinska Institute, Stockholm; Masaaki Kato, M.D., National Institute of Mental Health, Japan; and Paul Kielholz, M.D., University Psychiatric Clinic of Basel, Switzerland.

State Association Of Pharmacists Names New Officers

Robert M. Lambert, R.Ph., of Allen Park, is the new president of the 3,000-member Michigan State Pharmaceutical Association. He succeeds out-going president Lynn H. Cook, R.Ph., of Flint. Maurice Q. Bectel, R.Ph., Muskegon, is the new president-elect.

Mead Johnson -pharmaceuticals created for your specialized clinical needs

When Cerebrovascular Disturbances occur…



...with episodes of vertigo, headache, confusion, sensory loss, slurred speech, consider

VASODĪLAN®

(ISOXSUPRINE HCl)

to help relieve symptoms by preventing vasospasm and increasing cerebral blood flow

New 20 mg. strength now available: Vasodilan 20 mg. tablets for greater dosage simplicity and convenience. Recommended *initial* dose: one 20 mg. tablet q.i.d.

lthough not all clinicians agree on the value of vasodilators in vascular disease,[1] several investigators[2-5] have reported favorably on the effects of soxsuprine on cerebral blood flow. Effects have been demonstrated both by objective measurement[2,5] and observation of clinical improvement.[2-4]

ndications: Cerebrovascular insufficiency, arteriosclerosis obliterans, diabetic vascular diseases, thromboangiitis obliterans (Buerger's disease), aynaud's disease, postphlebitic conditions, acroparesthesia, frostbite syndrome and ulcers of the extremities (arteriosclerotic, diabetic, thrombotic). **omposition:** VASODĪLAN tablets, isoxsuprine hydrochloride 10 mg. and 20 mg. **Dosage:** Oral—10 to 20 mg. t.i.d. or q.i.d. **Contraindications nd Cautions:** There are no known contraindications to recommended oral dosage. Do not give immediately postpartum or in the presence of arterial leeding. **Side Effects:** Occasional palpitation and dizziness can usually be controlled by dosage reduction. As intramuscular administration of 10 ng. or more may cause brief hypotension and tachycardia, single intramuscular doses exceeding this amount are not ecommended. Complete details available in product brochure from Mead Johnson Laboratories. **References:** (1) Fazekas, . F.; Alman, R. W.; Ticktin, H. E.; Ehrmantraut, W. R., and Savarese, C. J.: Angiology *15:*No. 2 (Feb.) 1964. (2) Horton, . E., and Johnson, P. C., Jr.: Angiology *15*:70-74 (Feb.) 1964. (3) Clarkson, I. S., and LePere, D. M.: Angiology *11*:190-192 June) 1960. (4) Dhrymiotis, A. D., and Whittier, J. R.: Curr. Ther. Res. *4*:124-128 (April) 1962. (5) Whittier, J. R.: Angiology 5:82-87 (Feb.) 1964.

© 1970 MEAD JOHNSON & COMPANY • EVANSVILLE, INDIANA 47721 75970

Mead Johnson
LABORATORIES

MHC Inspires Detroit Teachers To Espouse Health Careers

By John Hyde
Coordinator, Health Manpower Programs
Michigan Health Council

So many of our students go through school without relating their school work to any particular occupational interest. With 40,000 occupations identified, it is important that each student select one which meets his needs and abilities. Needless to say, it takes time to explore and direct career goals, especially with so many possibilities in the offering.

This September, all eighth graders in 15 Detroit junior high schools will be studying occupational information in a semester-long course designed to direct them toward career planning. By the fall of 1971, all of the Detroit eighth graders will have the same opportunity.

In preparation for this venture, junior high teachers and counselors who will be teaching these classes were enrolled in a three-week summer "world of work" workshop sponsored by the Detroit Board of Education. Under the direction of Dr. Arthur Templeton, these teachers surveyed the occupational opportunities that will be available to these eighth graders.

With the health industry expecting to employ 10 percent of these students, the Michigan Health Council coordinated a program of health care information for presentation to this group.

It is most difficult to present the information concerning 240 distinct health fields in two days. With the use of resource people, we presented the various occupations by job families.

One day was spent at the University of Michigan Hospital visiting with people on the job. The other day was a classroom session using resource people from the various occupational fields. The new AMA movie, "A Matter of Opportunity," for recruiting minority students was previewed.

There is a tremendous number of health occupation resource people available and willing to tell students about the opportunity which is available to them. The Michigan Health Council can assist all groups by making the contacts.

We are eagerly awaiting the time when all Michigan students will have the opportunity to explore careers to aid them in planning for their future.

State Rheumatism And Arthritis Groups Form New Speakers' Bureau

The Michigan Rheumatism Society, in cooperation with the Michigan Chapter, Arthritis Foundation, has a new Speakers' Bureau which will provide experts to talk to lay and professional groups about arthritis in general and selected aspects of arthritis. Requests should be submitted at least three months in advance to Joan Boles, Michigan Chapter, Arthritis Foundation, 27308 Southfield Road, Lathrup Village 48075.

Second Exam Feb. 27-28 For Family Practice

The American Board of Family Practice announces that it will give its second examination for certification in various centers throughout the United States. The examination will be on Feb. 27-28, 1971, and the deadline for receiving completed applications in the board office is Nov. 1.

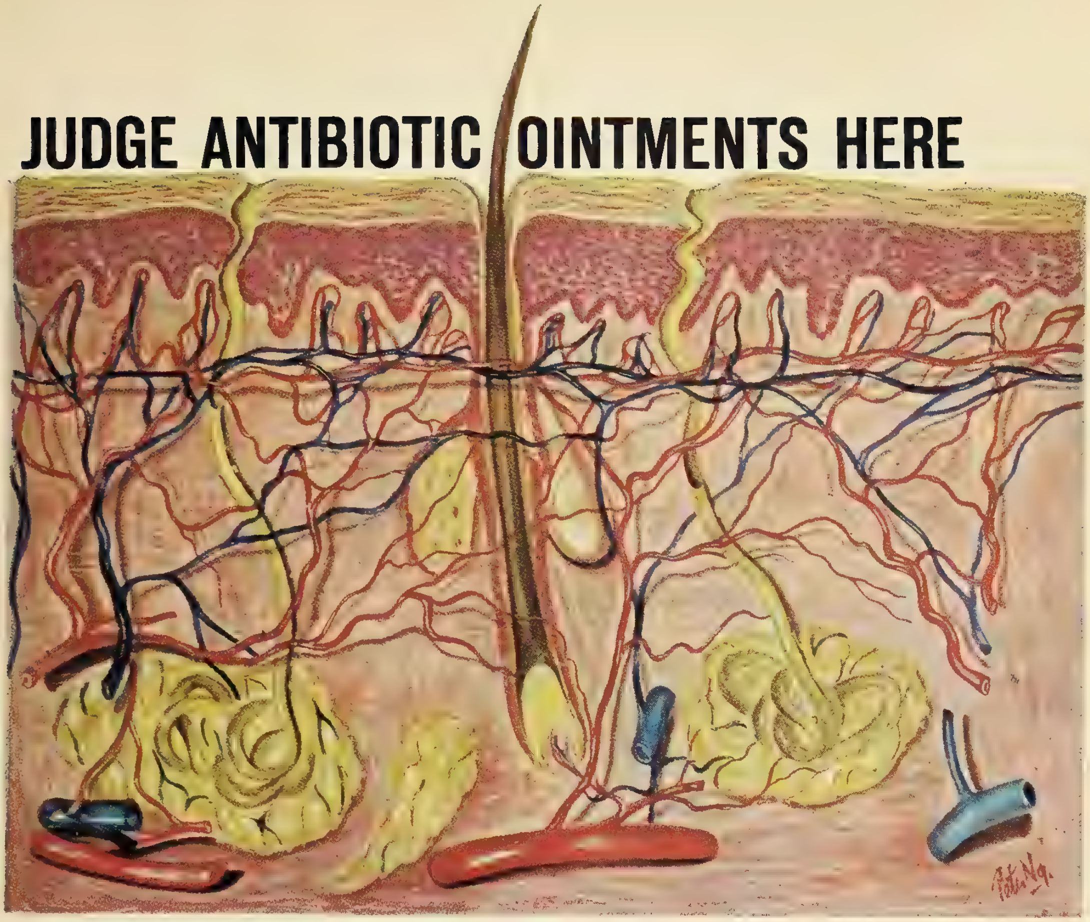
Further information may be obtained from Nicholas J. Pisacano, M.D., Secretary-Treasurer, American Board of Family Practice, Inc., University of Kentucky Medical Center, Annex No. 2, Room 229, Lexington, Ky. 40506.

Wisconsin-UP Meeting Sept. 19 for Specialists In Eye-Ear-Nose-Throat

The Wisconsin-Upper Michigan Society of Ophthalmology and Otolaryngology will hold its annual meeting Saturday, Sept. 19, at the Wisconsin Center in Madison.

All physicians practicing eye or ear, nose and throat, or both, in Upper Michigan who do not belong to this society are invited to join. Applications for membership should be sent to the secretary-treasurer, James Allen, M.D., Eye Clinic, University Hospitals, Madison, Wis. 53706.

JUDGE ANTIBIOTIC OINTMENTS HERE



Results on skin are final proof of any topical antibiotic's effectiveness

No in vitro test can duplicate a clinical situation on living skin. 'Neosporin' (polymyxin B—bacitracin—neomycin) Ointment has consistently proven its effectiveness in thousands of cases of bacterial skin infection. The spectra of the three antibiotics overlap in such a way as to provide bactericidal action against most pathogenic bacteria likely to be found topically. Diffusion of the antibiotics from the special petrolatum base is rapid since they are insoluble in the petrolatum, but readily soluble in tissue fluids. The Ointment is bland and nonirritating.

Caution: As with other antibiotic preparations, prolonged use may result in overgrowth of nonsusceptible organisms and/or fungi. Appropriate measures should be taken if this occurs. Articles in the current medical literature indicate an increase in the prevalence of persons allergic to neomycin. The possibility of such a reaction should be borne in mind.
Contraindications: This product is contraindicated in those individuals who have shown hypersensitivity to any of its components.
Supplied: Tubes of 1 oz., ½ oz. with applicator tip, and ⅛ oz. with ophthalmic tip.
Complete literature available on request from Professional Services Dept. PML.

'NEOSPORIN'®
brand

POLYMYXIN B-BACITRACIN-NEOMYCIN
OINTMENT

BURROUGHS WELLCOME & CO. (U.S.A.) INC., Tuckahoe, N.Y.

Clinical Extension of a pure Smooth Muscle Relaxant

TROCINATE®

Brand THIPHENAMIL HCl

400 mg./100 mg. S/C tablets

Trocinate relaxes all smooth muscles. Its direct action (musculotropic) does not involve the autonomic nervous system and it is not mydriatic. It is metabolized by the body and eliminated in the urine as harmless degradation products. Trocinate has a remarkable history of freedom from side-effects.

When a pure direct-acting smooth muscle relaxant is indicated, Trocinate is the drug of choice.

DIARRHEA (functional) . . . *the first 400 mg. tablet usually relieves the discomfort of diarrhea so promptly that it ceases to be a bother.*

DIVERTICULITIS—MUCOUS COLITIS *. . . the accompanying discomforts can be relieved by this direct smooth muscle relaxant.*

BLADDER SPASM . . . *relaxation is immediate. One or two tablets condition the bladder for cystoscopy in one hour.*

SPASTIC URETER . . . *the specific relaxing effect of Trocinate on the spastic ureter has been proven by animal studies and affirmed clinically. (J. Urol. 73:487-93)*

PRESCRIBING INFORMATION

WARNING: Do not give in advanced kidney or liver disease. PRECAUTIONS: Trocinate relaxes all smooth muscles. Large dosage or prolonged usage may cause feeling of weakness or can theoretically precipitate gall-bladder colic, due to relaxing the vascular and duct systems. Caution should be observed in patients with urinary bladder obstruction. DOSAGE: 400 mg. May be repeated in 4 hours. After relief, lengthen the dose frequency. (see side note)

WILLIAM P. POYTHRESS & CO., INC.
RICHMOND, VIRGINIA 23217
Manufacturers of Ethical Pharmaceuticals

NOTE: *The high therapeutic index of Trocinate permits its administration in dosage sufficient to relieve smooth muscle spasm promptly. 400 mg. dosage usually creates a therapeutic blood level. In reducing dosage after relief, lengthening the time between dosage rather than lessening the recommended dose is preferable. The prompt direct action allows a consciousness of the first suggestion of return of symptom . . . a guide to dose spacing and to determining when treatment is complete. A prescription for twelve or sixteen 400 mg. tablets will usually correct spasm and leave a few tablets for a reserve.*

Physicians, Legislators Enjoy MDPAC Dinner

The first annual "Gala Legislative Reception and Dinner" of the Michigan Doctors Political Action Committee was a great success. Held at the Wayne County Medical Society headquarters, the dinner featured a talk by Wayne County Sheriff William Lucas. Among those present were, from right, Mrs. Ernst and Reginald H. Ernst, M.D., president of the Detroit Medical Society; Louis R. Zako, M.D., Allen Park, dinner chairman and emcee; Mrs. Fryfogle and James D. Fryfogle, M.D., immediate past president of the Wayne County Medical Society; State Senator Lorraine Beebe; Mrs. Zako; Mrs. Lucas and Sheriff Lucas; William A. Mays, M.D., MDPAC member, and Homer C. Smathers, Wayne County Medical Society president-elect.

Others at the head table included, from left, Robert K. Whiteley, M.D., president of the Wayne County Medical Society; Mrs. Boddie and Arthur Boddie, M.D., president of the Wolverine Medical Society; Donato F. Sarapo, M.D., chairman of MDPAC, and Homer C. Smathers, M.D., WCMS president-elect.

Sheriff Lucas, second from right, told his audience that being a professional develops a sensitivity within the individual that is badly needed today and equips the individual to understand even if he does not agree. He talked, above, with, from left, Doctor Ernst; Mrs. Lucas; Mrs. Beebe; Mrs. Ulysses Boykin, wife of the Detroit public relations councilor for medical organizations; Mrs. Earl E. Weston, immediate past president of the MSMS Woman's Auxiliary and Doctor Boddie.

A portion of the crowd attending the recent "Gala Legislative Reception and Dinner" sponsored recently by MDPAC. The dinner drew members of the Michigan Legislature and medical community from throughout the Detroit area.

Schedule of 1970 Postgraduate Courses

University of Michigan Medical Center

The following courses are being offered during the 1970-71 academic year. Further information is available from the Department of Postgraduate Medicine, Towsley Center for Continuing Medical Education, Ann Arbor, Michigan 48104.

Family Practice

Otorhinolaryngology for Generalists (with Michigan Academy of General Practice)	Dec. 9, 1970
Family Practice Review (with Michigan Academy of General Practice)	Jan. 18-22, 1971

Interdisciplinary Courses

Medicolegal Investigation	Sept. 10 and Oct. 14, 1970 Mar. 10 and Apr. 21, 1971
Home Study Course in Electrocardiographic Diagnosis 30 weeks beginning	Oct. 6, 1970 and Feb. 2, 1971
Cardiology Kickoff (with Michigan Heart Association)	Oct. 17, 1970
Advances in Bedside Diagnosis	Oct. 28-30, 1970
International Symposium on Drug Abuse	Nov. 9-13, 1970
American Association of Automotive Medicine	Nov. 19-20, 1970
Inhalation Therapy Conference	Jan. 15-16, 1971
Applied Clinical Physiology	Feb. 22-24, 1971
Recent Advances in Therapeutics	Mar. 3-5, 1971
New Techniques in Crisis Intervention	Apr. 1, 1971
Electrocardiographic Diagnosis	Apr. 13-16, 1971
Emergency Room Medicine (at Wayne County General Hospital)	Apr. 14-15, 1971
Northern Michigan Summer Course	June 14-18, 1971

Internal Medicine

Cardiology	Sept. 16-17, 1970
Supportive Care of the Surgical Patient (at Henry Ford Hospital)	Nov. 23-24, 1970
Advances in Internal Medicine	Feb. 15-18, 1971
Obstructive Airway Disease	Apr. 28-29, 1971
Infections: Cause and Control (at Henry Ford Hospital)	May 12-13, 1971

Obstetrics and Gynecology

Obstetrics and Gynecology Conference	Mar. 29-31, 1971

Ophthalmology

Ophthalmology Conference	May 3-5, 1971

Otorhinolaryngology

International Symposium on Otophysiology	May 20-22, 1971

Pathology

Continuing Pathology Seminars on Neoplasia	Oct. 1 and Nov. 19, 1970 Feb. 25 and Apr. 22, 1971

Pediatrics

Advances in Immunity and Infectious Disease	Mar. 24-26, 1971

Radiology

Radiology Conference	Jan. 7-8, 1971

Surgery

Management of the Burned Patient	Feb. 25-27, 1971
Surgical Aspects of Diseases of the Liver and Pancreas	Mar. 15-16, 1971
Surgical Anatomical Review	Apr. 19-May 14, 1971

Notice of the continuing education courses being sponsored by Wayne State University School of Medicine and Michigan State University's College of Human Medicine will follow in the October issue of **Michigan Medicine.**

Smiles speak louder than words

for the good taste of Soyalac

Milk-free, hypo-allergenic Soyalac has a pleasing taste that is eagerly accepted by most infants. It's similar to mother's milk in composition and assimilation, much like cow's milk in consistency and completely free of fibre. Extensive clinical data support Soyalac's value in promoting growth and development. Soyalac is also excellent for growing children and adults.

Loma Linda
Soyalac
CONCENTRATED
LIQUID
Hypoallergenic
For Infants
Children and Adults

Available in
Concentrated Liquid or Powdered

Free Booklet and Samples

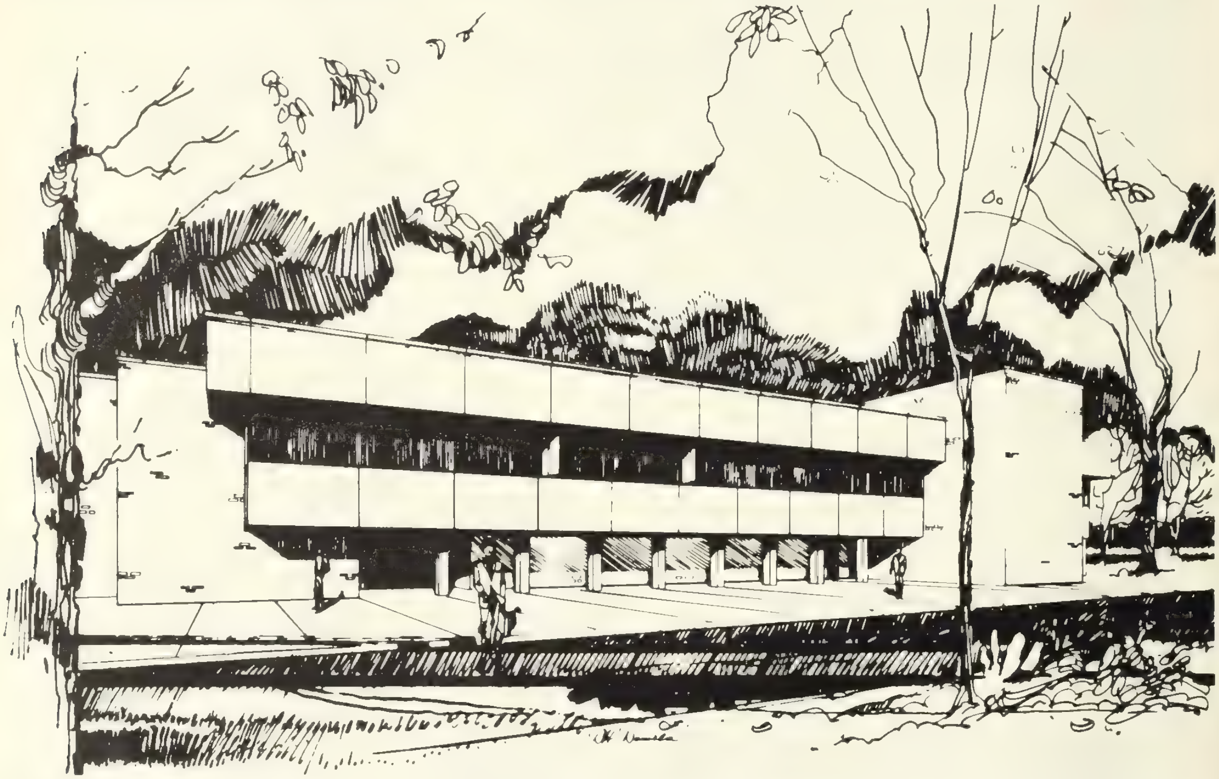
A request on your professional letterhead or prescription form will bring to you complete information and a supply of samples.

Soyalac

a product of
LOMA LINDA FOODS
MEDICAL PRODUCTS DIVISION
RIVERSIDE, CALIFORNIA
Mount Vernon, Ohio, U. S. A.

DRUG ABUSE...

INTERNATIONAL SYMPOSIUM For PHYSICIANS



Towsley Center – University of Michigan Medical Center

November 9-13, 1970

. . . to help the physician cope more effectively with drug abuse in patient care, in the community, in schools, courts and social agencies . . .

. . . the complete spectrum of drug abuse: medical, pharmacologic, psychiatric, legal, social and philosophic . . .

Among the National and International Faculty are:

Dr. Thomas Bewley	England	Dr. Jerome Jaffe	Chicago
Dr. Henry Brill	New York	Prof. Abraham Kaplan	Ann Arbor
Dr. Dale Cameron	World Health Organization	Dr. Masaaki Kato	Japan
Dr. Henry Elliott	California	Daniel P. Moynihan	Washington, D.C.
Dr. Leonard Goldberg	Sweden	Dr. Maurice Seevers	Ann Arbor
Dr. Leo Hollister	California	Dr. Joseph Seifter	New York

For further information write to: Department of Postgraduate Medicine
The University of Michigan
Ann Arbor, Michigan 48104

A
BUILDING BLOCK
TO RECOVERY

"Welcome back, Ann"
As adjunctive therapy
DOUBLE STRENGTH
Orenzyme®
Bitabs
One tablet q.i.d.
Trypsin 100 000 N.F Units, Chymotrypsin 8,000 N.F. Units; equivalent in tryptic activity to 40 mg. of N.F. trypsin
Reduces swelling
Hastens healing
Speeds recovery
trauma

One tablet q.i.d.

Indications: When used as adjunctive therapy for the rapid resolution of inflammation and edema, good results have been obtained in:
☐ Accidental Trauma ☐ Postoperative Tissue Reactions.
Other conventional measures of treatment should be used as indicated. In infection, appropriate anti-infective therapy should be given.
Contraindications: ORENZYME BITABS should not be given to patients with a known sensitivity to trypsin or chymotrypsin.
Precautions: It should be used with caution in patients with abnormality of the blood clotting mechanism such as hemophilia, or with severe hepatic or renal disease. Safe use in pregnancy has not been established.
Adverse Reactions: Adverse reactions with ORENZYME have been reported infrequently. Reports include allergic manifestations (rash, urticaria, itching), gastrointestinal upset and increased speed of dissolution of animal-origin surgical sutures. There have been isolated reports of anaphylactic shock, albuminuria and hematuria. Increased tendency to bleed has also been reported but, in controlled studies, it has been seen with equal incidence in placebo-treated groups. (See Precautions.) It is recommended that if side effects occur medication be discontinued.
Dosage: One tablet q.i.d.

THE NATIONAL DRUG COMPANY
DIVISION OF RICHARDSON-MERRELL INC.
PHILADELPHIA, PENNSYLVANIA 19144
TRADEMARK BITABS U S PATENT NO 3,004,893 9/70 0 009A 161

Orenzyme® Bitabs

Trypsin: 100,000 N.F. Units, Chymotrypsin: 8,000 N.F. Units; equivalent in tryptic activity to 40 mg. of N.F. trypsin

The causes of vaginitis are multiple

Trichomonads . . . monilia . . . bacteria

You can depend on AVC—comprehensive therapy that combats all three major vaginal pathogens, alone or in combination.

AVC

Cream (aminacrine hydrochloride 0.2%, sulfanilamide 15.0%, allantoin 2.0%)

Suppositories (aminacrine hydrochloride 0.014 Gm., sulfanilamide 1.05 Gm., allantoin 0.14 Gm.)

Contraindications: Known sensitivity to sulfonamides.

Precautions/Adverse Reactions: The usual precautions for topical and systemic sulfonamides should be observed because of the possibility of absorption. Burning, increased local discomfort, skin rash, urticaria or other manifestations of sulfonamide toxicity are reasons to discontinue treatment.

Dosage: One applicatorful or one suppository intravaginally once or twice daily.

Supplied: Cream – Four-ounce tube with or without applicator. Suppositories – Box of 12 with applicator.

TRADEMARK: AVC AV-007A 7/70 Y-149

THE NATIONAL DRUG COMPANY
DIVISION OF RICHARDSON MERRELL INC
PHILADELPHIA, PENNSYLVANIA 19144

AVC
The treatment is singular

Drip stopped, Congestion cleared

For upper respiratory allergies and infections, up to 12 hours clear breathing on one tablet. Dimetapp Extentabs® does an outstanding job of helping to clear up the stuffiness, drip and congestion of colds and upper respiratory allergies and infections. Each Extentab keeps working up to 12 hours. And for most patients drowsiness or overstimulation is unlikely.

INDICATIONS: Dimetapp is indicated for symptomatic relief of the allergic manifestations of respiratory illnesses, such as the common cold and bronchial asthma, seasonal allergies, rhinitis, conjunctivitis, and otitis. CONTRAINDICATIONS: Hypersensitivity to antihistamines. Not recommended for use during pregnancy. PRECAUTIONS: Until patient's response has been determined, he should be cautioned against engaging in operations requiring alertness. Administer with care to patients with cardiac or peripheral vascular diseases or hypertension. SIDE EFFECTS: Hypersensitivity reactions including skin rashes, urticaria, hypotension and thrombocytopenia, have been reported on rare occasions. Drowsiness, lassitude, nausea, giddiness, dryness of the mouth, mydriasis, increased irritability or excitement may be encountered. DOSAGE: 1 Extentab morning and evening. SUPPLIED: Bottles of 100 and 500.

A-H-ROBINS
A. H. Robins Company
Richmond, Va. 23220

Dimetapp Extentabs®

Dimetane® (brompheniramine maleate), 12 mg.; phenylephrine HCl, 15 mg.; phenylpropanolamine HCl, 15 mg.

Mylanta®
24 million hours
a day.

Through the day, every day,
ulcer patients take
one million doses of Mylanta
for relief of ulcer pain.

Mylanta®
LIQUID/TABLETS
aluminum and magnesium hydroxides plus simethicone

Good taste = patient acceptance
Relieves G.I. gas distress*
Non-constipating

*with the defoaming action of simethicone

Stuart
PHARMACEUTICALS Pasadena, Calif. 91109
Division of Atlas Chemical Industries, Inc., Wilmington, Del. 19899

medico-legal

(Editor's Note: The following article is quoted from the AMA CITATION newsletter of May 1, 1970, prepared by the AMA Law Department.)

Malpractice, Unnecessary Surgery, Failure To Obtain Informed Consent

A finding against two physicians for fraud and misrepresentation, malpractice, assault and battery, and breach of contract was upheld by a Michigan appellate court.

There was sufficient evidence to establish that the doctors undertook to perform a surgical operation which was unnecessary under the facts then existing, the court said. The prevailing standard of care required them to warn the patient of the potential dangers of the operation and to obtain her informed consent. The standard further required them to obtain more information than was available to them by examination of X-rays, medical records and history.

Their diagnosis of a present existing hydronephrosis did not meet the prevailing standard of care, the court ruled. The procedure employed was too radical — specifically, an operation producing a higher insertion of the ureter in the right kidney than existed before the operation and an angulation of the ureter. Those changes caused a stasis contributing to the formation of a calculus and the ultimate loss of the kidney.

Because the patient had not consented to this operation, the doctors committed assault and battery upon her person, the court held. Moreover, one of the doctors breached his contract with the patient when he relinquished control of the other doctor without her authorization and also when he was absent from the operation and when he was out of the state while the patient was undergoing postoperative treatment. The trial court's judgment against the two doctors was affirmed. —*Howell v. Carpenter,* 172 N.W. 2d 549 (Mich., Oct. 1, 1969; rehearing denied Nov. 18, 1969) *from Vol. 21, No. 2*

(Editor's Note: The following articles are quoted from the AMA CITATION newsletter of June 1, 1970, prepared by the AMA Law Department.)

Psychiatrist Liable for False Imprisonment, Assault and Battery

A psychiatrist was found liable to a woman for false imprisonment when the private psychiatric hospital in which she was confined permitted her "no communications in or out" except with her husband and children, at the orders of the psychiatrist. He was also liable to her for assault and battery when tranquilizer injections which he had prescribed were given to her forcibly, over her objections. A jury award of $40,000 was upheld by a Michigan appellate court.

At the request of the woman's husband, the psychiatrist had conversed with the woman at her home and also by telephone. He and another doctor certified to a county probate court that the woman was suffering from paranoid schizophrenia and should be hospitalized, in support of the husband's petition. The court ordered her hospitalization.

The psychiatrist claimed that his treatment of the woman was within the scope of a doctor-patient relationship as he had an authorized duty under the court order to treat her. However, the Michigan statute authorized treatment of a patient temporarily detained in a state hospital, but made no mention of treatment of a patient in a private hospital.

The doctor-patient relationship cannot be imposed upon a competent patient without her consent. A husband may not compel a competent wife to accept a doctor-patient relationship without her consent. The court pointed out that at the time of the psychiatrist's treatments, the woman had not been, nor had she ever been, adjudged to be mentally incompetent. Treatment must be shown to have been necessary treatment in order that it be permissible. "It is apparent," the court said, "that it is not desirable to give the doctor *carte blanche* authority to proceed with treatment in such cases in the absence of consent of a competent patient."

The forcible application of medication to her constituted assault and battery.

The woman obtained a release as soon as she managed to contact her lawyer. She was delayed in asserting her legal rights by the extensive restrictions placed upon her by the psychiatrist during her detention. The court, by its order, did not intend that she be prevented from such communications until her sanity hearing, the court held, although it added: "The isolation technique as a proper psychiatric tool may be unquestioned in cases where it is shown to be necessary and not violative of inherent legal rights."

Judgments in favor of the other doctor and the hospital were not involved in this appeal. — *Stowers* v. *Ardmore Acres Hospital,* 172 N.W.2d 497 (Mich. Ct. of App., Aug. 28, 1969)

from Vol. 21, No. 4

Former Mental Patient Competent as Witness

A trial judge did not abuse his discretionary powers when he allowed a witness who had spent some time in a mental institution to testify in a criminal prosecution, inasmuch as the witness had been adjudged sane about a month before the crime occurred, a Michigan appellate court held.

In a trial for armed robbery, the chief witness, who was a confessed participant, had spent time in a mental institution, but had been adjudged sane by the probate court about one month before the crime occurred. At the trial the accused tried to exclude the witness's testimony as incompetent or at least to have the witness testify in the absence of the jury.

The appellate court agreed that the trial judge did not abuse his discretionary powers in allowing the witness to testify since the witness was determined to be sane in a sanity restoration hearing preceding the crime. — *People of the State of Michigan* v. *Maglaya,* 169 N.W.2d 530 (Mich. Ct. of App., May 27, 1969)

from Vol. 2, No. 4

(Editor's Note: The following articles are quoted from the AMA Citation newsletter of June 15, 1970, prepared by the AMA Law Department.)

Action For Prenatal Injuries Not Allowed In Michigan

Damages may not be recovered for prenatal injuries sustained in an automobile accident, a Michigan appellate court held.

An action was brought on behalf of the estate of a child for injuries allegedly sustained as the result of a motorist running a red light and striking the automobile in which the child's mother was a passenger. At the time of the impact, the child was a nine-month-old fetus. He survived the impact but lived only three months after his birth.

The court, in affirming the motorist's motion to dismiss, held that persons suffering from prenatal injuries caused by the negligent conduct of others must go uncompensated.

The court noted, however, that there have been advancements in medical science which remove the problems of proof in this type of case and recommended that the case upon which this decision was based should be reconsidered. However, pending a reversal of that particular case, the law in Michigan denies damages for prenatal injuries. — *Marlow* v. *Krapek,* 174 N.W.2d 172 (Mich. Ct. of App., Dec. 4, 1969)

from Vol. 21, No. 5

Microscopic Slide Admissible

In a prosecution for rape, a trial court properly admitted in evidence a microscopic slide which allegedly showed sperm, as well as a physician's testimony that the sperm was taken from the victim's vagina, a Michigan appellate court ruled. The physician's testimony that the slide was a new and unused one that was taken from the manufacturer's container was an adequate foundation for the admission of the evidence. The physician's admission on cross-examination — that he would have no way of knowing whether sperm was on the slide before the test was taken — went only to the credibility, not the admissibility, of the evidence as to the slide. — *People of the State of Michigan* v. *Tucker,* 172 N.W.2d 712 (Mich. Ct. of App., Oct. 1, 1969; released for publication Dec. 17, 1969)

from Vol. 21, No. 5

REGIONAL LIBRARY RECEIVES 47,000 REQUESTS IN FIRST YEAR

Approximately 47,000 requests for biomedical information were received by the Detroit-based Regional Medical Library during 1969, its first year of existence.

The regional library, which serves the health professions in the states of Michigan, Ohio and Kentucky, was established by the University of Detroit and Wayne State University in January, 1969. A $100,000 grant made at that time under the Medical Library Assistance Act of 1965 has been renewed for 1970 for the library, which has its headquarters in the Wayne State University School of Medicine Library. Purpose of the library is to improve the flow of biomedical information through local medical libraries to medical practitioners, researchers and educators throughout the three-state area.

Participating institutions are Michigan State University, the University of Michigan, Cleveland Health Sciences Library, Ohio State University, Medical College of Ohio at Toledo, University of Cincinnati, University of Kentucky and University of Louisville.

Medical technology is demanding enough--

Here's how to relieve the demands of business:

— and enjoy personal satisfaction, peace of mind and freedom of time greater than you may have imagined possible.

Just a few years ago, a group of doctors in Kentucky resolved to make their practices simpler and more profitable. They formed a non-profit corporation, the Professional Service Corporation Association. The doctors talked with many professional consultants. Together they explored every aspect of practice — office procedure, billing, accounting, salaries, fringe benefits, insurance, retirement, equipment — even auto leasing — literally every business demand. Time and energy were lavished on every detail. Each was honed, polished and perfected. Now, benefits in each of these areas are available to PSCA members.

Specific business guidelines are the key

You may unknowingly be using business techniques discarded years ago by professional businessmen. You may be needlessly hampered by restrictions — penalized by advice from persons not knowledgable in medicine. Today, PSCA guidelines for systematic and simplified business procedures can be applied to incorporated practices. Remarkable benefits are immediately available.

Get every benefit you're entitled to

Professional Service Corporation Association (PSCA) offers members complete guidance to qualify for every benefit legitimately available. You'll find this list surprisingly long. Exceptional financial rewards are possible. Details of planned incentives and benefits for employees are covered. Carefully qualified and professional services are made available exclusively to PSCA members.

Direct and immediate cash savings — three and four times your membership fee — may be realized in a single business transaction.

Here's how you can get these remarkable benefits

Regular PSCA membership is open to incorporated professionals exclusively. Junior membership to qualified senior students, interns, residents and fellows. Dues for Regular membership are $25 for each stockholder-employee per year. $10 for Junior members. Complete the coupon below and send it with your check today. You'll be provisionally enrolled until qualification is approved. Benefits of membership come just as easily as this means of joining. Full information covering all details will start you enjoying your chosen profession as never before.

Professional Service Corporation Association, Inc.
A non-profit organization formed and controlled by doctors
1622 Commonwealth Building, Louisville, Ky. 40202
Phone: 502/583-8164

To PSCA: Enroll me as a ☐ Regular ☐ Junior member for one year. My practice specialty is________________.
Send full information and details to:

NAME____________________________

TITLE____________________________

CORPORATE NAME______________________

ADDRESS__________________________

CITY____________STATE_______ZIP_______
(Your fee is refundable if you do not qualify.)

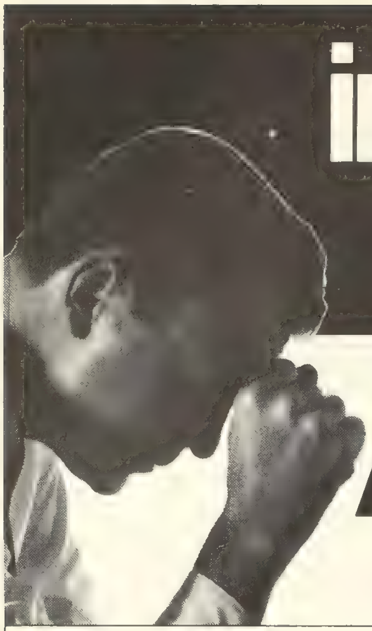
The treatment of

impotence

in the American male is complex.
The concept of chemotherapy plus the
physician's psychological support is confirmed
as effective therapy.

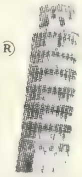
NEW CLINICAL STUDY

The Treatment of Impotence
with Methyltestosterone Thyroid
(100 patients — Double-Blind Study)
T. Jakobovits
Fertility and Sterility, January 1970
Official Journal of the
American Fertility Society



Android®

(thyroid-androgen) tablets



Double-Blind Study and Type of Patient: 1 patients suffering from undifferentiate impotence. Examination revealed the patien were within the average range of 17-Ket steroid excretion and protein bound iodin Except for fatigue in some patients all we in good health. Study was for one month duration. Each patient received one tabl 3 times daily.

Results: Of the patients receiving the acti medication (Android) a favourable respons was seen in 78%. This compares with 40% wi those on placebo. 80% of the patients treated wi the active ingredients showed relief in fatigue con pared with 42% of those receiving the placeb Although psychotherapy is indicated in patients su fering from functional impotence the concomitant ro of chemotherapy (Android) cannot be disputed.

Contraindications — Methyltestosterone is not to be used in malignancy of reproductive organs in ma coronary heart disease Thyroid is not to be used in heart disease, hypertension unless the metab rate is low

References: 1. **Montesano, P., and Evangelista, I.** Methyltestosterone-thyroid treatment of sex impotence Clin Med 12:69, 1966. 2. **Dublin, M. F.** Treatment of impotence with methyltestoster thyroid compound West Med 5:67, 1964 3. **Titeff, A. S.** Methyltestosterone-thyroid in treating impoten Gen Prac 25:6, 1962 4. **Hellman, L., Bradlow, H. L., Zumoff, B., Fukushima, D. K., and Gallagher, T.** Thyroid-androgen interrelations and the hypocholesteremic effect of androsterone. J Clin Endocr 19:9 1959 5. **Farris, E. J., and Colton, S. W.** Effects of L-thyroxine and liothyronine on spermatogene J Urol 79:863, 1958. 6. **Osol, A., and Farrar, G. E.** United States Dispensatory (ed. 25). Lippincott, Ph delphia, 1955, p. 1432. 7. **Wershub, L. P.** Sexual Impotence in the Male. Thomas, Springfield, Ill., 1959, pp. 79-99.

REFER
PD

Choice of 4 strengths:

Android

Each yellow tablet contains
Methyl Testosterone ..2.5 mg.
Thyroid Ext. (1/6 gr.) ..10 mg.
Glutamic Acid ....50 mg
Thiamine HCL ....10 mg
Dose: 1 tablet 3 times daily
Available:
Bottles of 100, 500, 1000

Android-HP
HIGH POTENCY

Each red tablet contains:
Methyl Testosterone ..5.0 mg.
Thyroid Ext. (½ gr.) ...30 mg.
Glutamic Acid ....50 mg
Thiamine HCL ....10 mg.
Dose: 1 tablet 3 times daily.
Available:
Bottles of 100, 500, 1000.

Android-X
EXTRA HIGH POTENCY

Each orange tablet contains:
Methyl Testosterone .12.5 mg.
Thyroid Ext. (1 gr.) ....64 mg.
Glutamic Acid ....50 mg.
Thiamine HCL ....10 mg.
Dose: 1 or 2 tablets daily.
Available:
Bottles of 60, 500.

Android-Plus
WITH HIGH POTENCY
B-COMPLEX AND VITAMIN C

Each white tablet contains:
Methyl Testosterone ..2.5 mg.
Thyroid Ext. (¼ gr.) ...15 mg.
Ascorbic Acid (Vit. C) .250 mg.
Thiamine HCL ....25 mg.
Glutamic Acid ....100 mg.
Pyridoxine HCL ....5 mg.
Niacinamide ....75 mg.
Calcium Pantothenate .10 mg
Vitamin B-12 ....2.5 mcg
Riboflavin ....5 mg.
Dose: 2 tablets daily.
Available: Bottles of 60, 500.

Write for literature and samples: BROWN **THE BROWN PHARMACEUTICAL CO., INC.** 2500 West 6th Street, Los Angeles, California 900
A SUBSIDIARY OF ASSOCIATED CARE ENTERPRISES, INC.

Established 1924

MERCYWOOD HOSPITAL

4038 Jackson Road
Conducted by Sisters of Mercy
Ann Arbor, Michigan
Telephone — 313 663-8571

Mercywood Hospital is a private neuropsychiatric hospital licensed by the Michigan Department of Mental Health. Mercywood specializes in intensive, multi-disciplinary treatment for emotional and mental disorders.

Accredited by the Joint Commission on Accreditation of Hospitals and the National League of Nursing. A full Blue Cross participating hospital.

Certified for: Medicare and M.A.A. programs

PSYCHIATRIC STAFF

Lyle M. Allis, M.D.
Robert J. Bahra, M.D.
Dean P. Carron, M.D.
Francis M. Daignault, M.D.
Gordon C. Dieterich, M.D.
James R. Driver, M.D.
Stuart M. Gould, Jr., M.D.
Leonard E. Himler, M.D.*
Sydney Joseph, M.D.
Jacob J. Miller, M.D.
Rudolf Nobel, M.D.
Richard D. Watkins, M.D.
Stephen C. Mason, M.D.
Philip M. Margolis, M.D.
Hubert Miller, M.D.

* 1904 - 1967

SEE YOU IN DETROIT!

Michigan physicians gathering in Detroit Sept. 20-24 for the 1970 MSMS Annual Session will find the Motor City filled with many sight-seers' delights. Among them, pictured on this page, are beautiful buildings, such as the Detroit Historical Museum, corner of Kirby Street and Woodward Avenue; the Michigan Consolidated Gas Building, in the heart of the downtown Detroit area near the river, and the elegant McGregor Conference Center on the Wayne State University campus. Both latter buildings were designed by Minoru Yamasaki of Troy, the world-renowned architect who also created the plans for the beautiful MSMS headquarters building in East Lansing. Other attractions for the Annual Session-goer off-hours include the Bob-Lo boat excursions down the Detroit River.

Michigan Consolidated Gas Building

DETROIT HISTORICAL MUSEUM

Detroit Historical Museum

McGregor Conference Center

Photos Courtesy of
The **Plymouth Traveler**

Bob-Lo Excursion Boat

The tall buildings of downtown Detroit loom beyond the Ambassador Bridge in this photo from the Canadian side of the Detroit River. The city is the scene of the 1970 MSMS Annual Session Sept. 20-24 at the Sheraton-Cadillac Hotel.

Delegates and Alternates For 1970 MSMS House of Delegates Meeting

OFFICERS

Speaker:

James B. Blodgett, MD, 76 W. Adams, Detroit 48226

Vice Speaker:

Vernon V. Bass, MD, 3322 Davenport, Saginaw 48602

Immediate Past President:

James J. Lightbody, MD, 7815 E. Jefferson, Detroit 48214

Secretary:

Kenneth H. Johnson, MD, 1116 Michigan Natl. Tower, Lansing

ALLEGAN

James I. Clark, MD, Route 1, Box 25 D, Fennville, Michigan 49408
Kenneth C. Miller, MD, Saugatuck 49453

ALPENA-ALCONA-PRESQUE ISLE

Frederick C. O'Dell, Jr., MD, 615 W. Chisholm Street, Alpena 49707
Edward A. Hier, MD, 125 No. Second Avenue, Alpena 49707

BARRY

Robert J. Huebner, MD, 1005 W. Green, Hastings 49058
Wesley G. Logan, MD, 1005 West Green, Hastings 49058

BAY-ARENAC-IOSCO

John T. Geneczko, MD, 1308 Columbus, Bay City 48706
Paul W. Rowe, MD, Mercy Hospital, Bay City 48706
David Standiford, MD, 2108 Sixteenth St., Bay City 48706
Walter L. Howland, MD, 2110 E. Sixteenth Street, Bay City 48706

BERRIEN

F. Alan Kennedy, MD, 315 Fidelity Building, Benton Harbor 49022
Frederick H. Lindenfeld, MD, 8 North St. Joseph St., Niles 49120
John H. Carter, MD, 687 East Empire Avenue, Benton Harbor 49022
Noel J. Hershey, MD, 122 Grant St., Niles 49120

BRANCH

John J. Rick, MD, 235 E. Chicago St., Coldwater 49036
Henry C. Gomley, MD, 130 E. Chicago St., Bronson 49028

CALHOUN

George T. Kelleher, MD, 235 North Aevnue, Battle Creek 49017
Russel C. Rowan, MD, 500 S. Ionia, Albion 49224
Salvatore A. Yannitelli, MD, 710 North Avenue, Battle Creek 49017
Richard H. Allen, MD, 191 College St., Battle Creek 49017
Alfred G. McCuaig, MD, 719 Capital Avenue, SW, Battle Creek 49017
Francis L. Lam, MD, 408 Capital Avenue, Battle Creek 49017
(Tentative)

CASS

Lowell D. Smith, MD, 109 School St., Cassopolis 49031

CHIPPEWA-MACKINAC

Donald D. Finlayson, MD, 301 E. Spruce St., Sault Ste. Marie 49783
William F. Mertaugh, MD, 104 Spruce St., Sault Ste. Marie 49783

CLINTON

James M. Grost, MD, Park Avenue, St. Johns 48879
Paul F. Stoller, MD, St. Johns 48879

DELTA-SCHOOLCRAFT

Donald N. Fitch, MD, Doctor's Park, Escanaba 49829
Merle E. Wehner, MD, 131 River Street, Manistique 49854

DICKINSON-IRON

Donald T. Anderson, MD, Dickinson County Memorial Hospital, Iron Mountain 49801
Paul L. Trump, MD, Commercial Bank Building, Iron Mountain 49801

EATON

Eber B. Sherman, MD, 501 Carlisle St., Eaton Rapids 48827
Byron P. Brown, MD, 541 Lansing, Apt. 6, Charlotte 48813

GENESEE

Clifford W. Colwell, MD, 2011 Briarhill Rd., Flint 48503
Ernest P. Griffin, MD, 1505 Arrow Lane, Flint 48507
Lewis E. Simoni, MD, 9109 S. Saginaw Rd., Grand Blanc 48439
Richard J. McMurray, MD, 3018 Begole St., Flint 48504
John W. MacKenzie, Jr., MD, 1295 DyeKrest Circle, Flint 48504
Charles A. Thompson, MD, 1201 San Juan Drive, Flint 48504
Lawrence G. Bateman, MD, 1708 E. Second St., Flint 48503
John Quin, Jr., MD, 417 Greenfield Avenue, Flint 48503
Charles R. Gumpper, MD, 4437 Morrish Rd., Swartz Creek 48473
Paul E. Schroeder, MD, 1825 Lynbrook Drive, Flint 48507
Louis B. Coriasso, MD, 9224 Happy Hollow Ct., Grand Blanc 48439
John C. Benson, MD, 2602 Pewanaga Place, Flint 48507
Glenn E. Moore, MD, 1915 Lincoln Drive, Flint 48503
Frederick W. Van Duyne, MD, 2849 Miller Road, Flint 48503

GOGEBIC

John R. Franck, Jr., MD, 401 Sunday Lake, Wakefield 49968
Not Elected

GRAND TRAVERSE-LEELANAU-BENZIE

Frank H. Power, MD, 116 Cass, Traverse City 49684
Arthur F. Dundon, MD, 1100 Sixth, Traverse City 49684
Bernard J. Sweeney, MD, 1100 Sixth, Traverse City 49684
Richard L. Thirlby, MD, 228 S. Madison, Traverse City 49684

(Continued on Page 839)

Schering

After only one year:

Administered
to more people
than live in
Grand Rapids.*

Injectable
Garamycin®
brand of
gentamicin sulfate
injection

An estimated 208,000 patients have received GARAMYCIN Injectable to date. The population of Grand Rapids is 205,000. (Estimated 1969 figure from The New York Times Encyclopedic Almanac 1970.)

See Clinical Considerations section on last page...

Injectable
Garamycin®
brand gentamicin sulfate injection

ADULT DOSAGE GUIDELINES

See definitive prescribing information in Package Insert.

Patients with Normal Renal Function

Total Daily Dose (administered in two, three, or four divided doses)			
	Less Severe	**Resistant/ Moderately Severe**	**Serious/ Life-Threatening**
Urinary Tract Infections (due to susceptible strains of gram-negative bacteria)†	0.8-1.2 mg./kg. for 7-10 days	Larger doses or additional antibacterial therapy should be considered in severe urinary tract infections or in resistant cases involving the renal parenchyma or anatomic anomaly.	up to 5 mg./kg.
Other Infections including bacteremia, infected surgical wounds, severe soft tissue infections, and respiratory tract infections (due to susceptible strains of gram-negative bacteria)	3 mg./kg. for 7-10 days		

†Alkalinization of the urine may be a useful therapeutic adjunct.

Patients with Impaired Renal Function
To minimize the risk of ototoxicity in patients with impaired kidney function, only the first dose should be that normally recommended. Each subsequent dose should be half or less of that recommended for patients with normal renal function, depending upon the degree of renal impairment.

In patients with renal failure who are undergoing 14-hour hemodialysis twice weekly, administration of 1 mg./kg. GARAMYCIN Injectable at the end of each dialysis period has been suggested.

Clinical Considerations

Indications: GARAMYCIN Injectable is clinically effective in infections due to susceptible strains of gram-negative bacteria, including *Pseudomonas aeruginosa,* and species of indole-positive and indole-negative *Proteus, Escherichia coli,* and *Klebsiella-Aerobacter.* Bacteriologic studies should be conducted to identify the causative organism and to determine its sensitivity to gentamicin sulfate. Sensitivity discs of the drug are available for this purpose. If the susceptibility tests indicate that the causative organism is resistant to gentamicin sulfate, other appropriate antibiotic therapy should be instituted.

IN VITRO INHIBITION OF CLINICALLY IMPORTANT BACTERIA BY GENTAMICIN SULFATE (TUBE DILUTION STUDIES)

BACTERIA	No. of Strains Tested	No. of Strains (%) Inhibited by: 4 mcg./cc. or less		8 mcg./cc. or less*		No. of *In Vitro* Studies
Staphylococcus aureus	1,210	1,200	(99%)	1,206	(99%)	11
Pseudomonas aeruginosa	885	771	(87%)	828	(93%)	16
Escherichia coli	836	736	(88%)	779	(93%)	11
Indole-positive and indole-negative *Proteus* species	477	210	(44%)	358	(75%)	12
Klebsiella-Aerobacter species	292	205	(70%)	231	(79%)	10

*Number of strains (%) of gram-negative bacteria inhibited by 10 mcg./cc. or less are as follows: *Pseudomonas aeruginosa,* 828 (93%); *Escherichia coli,* 792 (95%); *Proteus* species, 393 (82%); *Klebsiella-Aerobacter* species, 284 (97%). From same studies as above.
Source: Package Insert

This drug should be limited to the treatment of serious infections caused by gram-negative bacteria, particularly *Pseudomonas aeruginosa, Proteus* and other susceptible organisms, with due regard for relative antibiotic toxicity. Therefore, the drug should be considered for use against gram-negative: 1. Bacteremia; 2. Infected surgical wounds; 3. Severe soft tissue infections, including burns complicated by sepsis; 4. Respiratory tract infections; and 5. Selected cases of urinary tract infection.

Contraindications: GARAMYCIN Injectable is contraindicated in individuals with a history of hypersensitivity or toxic reactions t gentamicin.

Warnings: Patients receiving treatment with GARAMYCIN should be under close clinical observation because of the toxicity associated with the use of this drug. Ototoxicity, vestibular and auditory, can occur in patients, primarily those with preexisting renal damage, treated with GARAMYCIN Injectable, usually for longer periods or with higher doses than recommended.

GARAMYCIN Injectable is potentially nephrotoxic, and this should be kept in mind when it is used in patients with preexisting renal impairment. Kidney function diminished by infection of the upper urinary tract may, however, improve during effective treatment with GARAMYCIN Injectable.

Concurrent administration of potentially ototoxic drugs such as streptomycin and kanamycin or of potentially nephrotoxic drugs such as polymyxin, colistin, and kanamycin with gentamicin sulfate has not been shown to afford any clinical advantages and, moreover may result in additive toxicity. Monitoring of vestibular, cochlear, and renal function will provide guidance for therapy in such cases.

Precautions: In patients with impaired renal function in whom serious infection develops, serum concentrations of the drug ma rise, with consequently increased risk of ototoxicity. In these patients or in those in whom recommended dosage or duration o therapy must be exceeded as a life-saving measure, routine studie of kidney function should be performed when possible. These ma be supplemented by evaluation of the vestibular and auditory function and measurement of serum concentration of the drug whe feasible. Serum concentrations of gentamicin should be maintaine below the range of 10-12 mcg./ml. to reduce risk of ototoxicity.

Ordinarily, treatment should not be given for more than 7 to 1 days or be repeated unless required for serious infection not responsive to other agents.

As with other antibiotics, treatment with GARAMYCIN Injectabl may occasionally result in overgrowth of nonsensitive organisms. I superinfection occurs, appropriate therapy is indicated.

Safety for use in pregnancy or the potential for fetal ototoxicity o nephrotoxicity have not been established. Studies in pregnant animals have not revealed teratogenic or ototoxic effects in the fetus GARAMYCIN Injectable should not be used in pregnant patients o in women of childbearing age unless its use is deemed advisabl by the physician.

Adverse Reactions: The overall incidence of ototoxicity considere related to treatment with GARAMYCIN Injectable was 2.8 per cen (16 of 565 patients). Contributory factors (two or more factors wer relevant to most patients) were as follows: 10 had azotemia, 1 received a total of 1 gram or more of the drug, 7 had recently received other potentially ototoxic antibiotics (streptomycin or kanamycin), and 5 were over 60 years of age. Six also had decrease high-tone hearing acuity, which returned to or toward normal i the 4 patients retested.

Analysis of BUN data indicated that 4 (2%) of 172 patients showe increases in BUN that were probably related to treatment wit GARAMYCIN Injectable. Of 20 increases probably or possibly relate to treatment, 7 were reversible, 9 occurred in terminal patients, an 4 had no follow-up.

Other adverse reactions associated with treatment were one instanc each of urticaria, decreased hematocrit, and reversible depressio of granulocytes with normal bone marrow. Other rarely reporte and possibly treatment-related adverse reactions were anemia, increased reticulocyte count, rash, purpura, drug fever, hypotensio convulsions, twitching, salivation, nausea, vomiting, increased transaminase activity (SGOT or SGPT), increased serum bilirubin, decreased serum calcium, and joint pain.

Packaging: GARAMYCIN Injectable, 40 mg./cc., 2-cc. multiple-dos vials, for intramuscular administration.

For more complete prescribing details, consult package insert o Physicians' Desk Reference. Schering literature is also availabl from your Schering Representative or Medical Services Departmen Schering Corporation, Union, New Jersey 07083.

AHFS CATEGORY 8:12.28

S-0

2 ways to give your patients a month's therapeutic supply of Vitamin C:
40 pounds of spinach or 30 Allbee® with C
30 Capsules
Allbee® with C
Each capsule Contains:
Thiamine mononitrate (Vit. B1) 15 mg
Riboflavin (Vit. B2) 10 mg
Pyridoxine hydrochloride (Vit. B6) 5 mg
Niacinamide 50 mg
Calcium pantothenate 10 mg
Ascorbic acid (Vit. C) 300 mg
A·H·ROBINS
AHR
AHR

Although raw spinach is an excellent source of vitamin C, your patient would have to eat 40 pounds a month (about 1⅓ lbs. a day) to get as much ascorbic acid as is contained in just one bottle of 30 Allbee with C capsules (taken one capsule daily). If the spinach is cooked, a person would have to ingest more than twice as much because cooking destroys much of the vitamin C, and still more is lost when the liquid is drained off. Allbee with C also contains therapeutic amounts of B-complex vitamins. This handy bottle of 30 capsules gives your patient a month's supply at a very reasonable cost. Also the economy size of 100. Available at pharmacies on your prescription or recommendation.

A. H. Robins Company, Richmond, Va. 23220

A·H·ROBINS

Main
DONNAT
2 tab
3 tim

vacation in
a vial:
the spasm
reactors
in your practice
deserve

"the Donnatal® Effect"

	each tablet, capsule or 5 cc. of elixir (23% alcohol)	each Donnatal No. 2	each Extentab®
hyoscyamine sulfate	0.1037 mg.	0.1037 mg.	0.3111 mg.
atropine sulfate	0.0194 mg.	0.0194 mg.	0.0582 mg.
hyoscine hydrobromide	0.0065 mg.	0.0065 mg.	0.0195 mg.
phenobarbital	(¼ gr.) 16.2 mg.	(½ gr.) 32.4 mg.	(¾ gr.) 48.6 mg.
(Warning: may be habit forming)			

Brief Summary. Blurring of vision, dry mouth, difficult urination, and flushing or dryness of the skin may occur on higher dosage levels, rarely on usual dosage. Administer with caution to patients with incipient glaucoma or urinary bladder neck obstruction. Contraindicated in acute glaucoma, advanced renal or hepatic disease or a hypersensitivity to any of the ingredients.

A. H. ROBINS COMPANY, RICHMOND, VIRGINIA 23220

A·H·ROBINS

GRATIOT-ISABELLA-CLARE
John M. Wood, MD, Davis Clinic, Mt. Pleasant 48858
Jack M. Stack, MD, Wolfe Building, Alma 48801

HILLSDALE
Clark B. Smith, MD, 252 S. Howell, Hillsdale 49242
John Tarr, MD, Camden 49232

HOUGHTON-BARAGA-KEWEENAW
Paul G. Goodreau, MD, 416 Sheldon Avenue, Houghton 49931
David H. Gilbert, MD, 146 Osceola Street, Laurium 49913

HURON
Charles W. Oakes, Jr., MD, Resort Road, Harbor Beach 48441
Kenneth B. Herrington, MD, 317 N. Port Crescent, Bad Axe 48413

INGHAM
Charles O. Long, Jr., MD, 1715 Roseland, East Lansing 48823
Robert M. Stow, MD, 2909 E. Grand River, Lansing 48912
D. Bonta Hiscoe, MD, 2909 E. Grand River, Lansing 48912
David Kahn, MD, 2909 E. Grand River, Lansing 48912
Herbert W. Harris, MD, 919 Chester Rd., Lansing 48912
Harry C. George, MD, 909 Abbott Road, E. Lansing 48823
Benjamin J. Stone, MD, 1005 Abbott Rd., E. Lansing 48823
Robert G. Combs, MD, 1023 E. Michigan Ave., Lansing 48912
George D. Stilwill, MD, 2909 E. Grand River, Lansing 48912
James F. Scallin, MD, 810 W. Saginaw, Lansing 48915
Joseph L. Sheets, MD, 2909 E. Grand River, Lansing 48912
Harold E. Crow, MD, 2909 E. Grand River, Lansing 48912

IONIA-MONTCALM
Robert E. Rice, MD, 420 S. Bower, Greenville 48838
Richard E. Campbell, MD, 104 S. Kidd, Ionia 48846

JACKSON
F. Patrick McQuillan, MD, 611 Center, St., Jackson 49203
Richard C. Deming, MD, 724 W. Franklin, Jackson 49201
Edward R. Weddon, MD, R.F.D. #2, Stockbridge 49285
Duane M. Allen, MD, Hanover Medical Center, Hanover 49241

KALAMAZOO
W. Kaye Locklin, MD, 1141 S. Rose St., Kalamazoo 49001
A. John Neerken, MD, 404 Bronson Medical Center, Kalamazoo 49006
Thomas E. Andrews, MD, 1634 Gull Rd., Kalamazoo 49001
Richard J. Bower, MD, 325 E. Centre, Portage 49081
Roger A. Scholten, MD, 219 Bronson Medical Center, Kalamazoo 49006
George J. Hoekstra, MD, 100 Maple Street, Parchment 49004
Robert C. Kettunen, MD, 507 Bronson Medical Center, Kalamazoo 49006
John L. Kihm, MD, 1219 S. Park Street, Kalamazoo 49001
Paul L. VanDenBrink, MD, 208 Bronson Medical Center, Kalamazoo 49006

KENT
Harvey M. Andre, MD, 500 Cherry St., SE, Grand Rapids 49503
Noyes L. Avery, Jr., MD, 515 Lakeside Drive, SE, Grand Rapids 49506
Fred C. Brace, MD, 1498 Lake Drive, SE, Grand Rapids 49506
Frederick S. Gillett, MD, 50 College Ave., SE, Grand Rapids 49503
William Haeck, MD, 245 State St., SE, Grand Rapids 49502
Jack Hoogerhyde, MD, 26 Sheldon Ave., SE, Grand Rapids 49502
Jack G. Lukens, MD, 245 State St., SE, Grand Rapids 49502
Victor A. Notier, MD, 50 College Ave., SE, Grand Rapids 49503
Kornelius Van Goor, MD, 26 Sheldon Ave., SE, Grand Rapids 49502
Gordon L. Bartek, MD, 833 Lake Drive, SE, Grand Rapids 49506
Robert D. Burton, MD, 515 Lakeside Drive, SE, Grand Rapids 49506
William E. Kincaid, MD, 100 Michigan St., NE, Grand Rapids 49503
Joseph R. Lentini, MD, 303 Fulton St., E, Grand Rapids 49503
Robert S. Levine, MD, 50 College Ave., SE, Grand Rapids 49503
John C. Montgomery, MD, 1810 Wealthy St., SE, Grand Rapids 49506
Robert J. Raiman, MD, 50 College Ave., SE, Grand Raipds 49503
Richard A. Rasmussen, MD, 1810 Wealthy St., SE, Grand Rapids 49506
William G. Zimmerman, MD, 435 Cherry St., SE, Grand Rapids 49502

LAPEER
Charles E. Conaway, MD, 1257 N. Main St., Lapeer 48446
Merle Bennet Haney, MD, 409 E. St. Clair St., Almont 48003

LENAWEE
Donato F. Sarapo, MD, Mill Road, Adrian 49221
Eleanor P. Skufis, MD, 201 Orchard R., Adrian 49221

LIVINGSTON
Edwin S. Woodworth, MD, 1200 Byron Rd., Howell 48843
Thomas F. Higby, MD, 124 N. Grand Ave., Fowlerville 48836

LUCE
Bernhard G. Keizer, MD, Newberry State Hospital, Newberry 49868
R. P. Hicks, MD, 210 W. John St., Newberry 49868

MACOMB
Charles M. Ebner, MD, 25520 Little Mack, St. Clair Shores 48081
Peter V. Kane, MD, 230 North, Mt. Clemens 48043
Earl A. Rinkenberger, MD, 243 So. Gratiot, Mt. Clemens 48043
Thomas J. Setter, MD, 319 N. Gratiot, Mt. Clemens 48043
Orville Oughtred, MD, 26401 Harper Avenue, St. Clair Shores 48081
Herbert M. Hiller, MD, 13500 Twelve Mile, Warren 48093
William C. Wyte, MD, 263 So. Gratiot, Mt. Clemens 48043
Gerald W. Morris, MD, 14 Belleview, Mt. Clemens 48043

MANISTEE
Donald N. Schwing, MD, Forest Clinic Building, Manistee 49660
David A. Wild, MD, 84 Cypress St., Manistee 49660

MARQUETTE-ALGER
George M. Wilson, Jr., MD, Medical Center, 1414 W. Fair Ave., Marquette 49855
Frederick C. Sabin, MD, Medical Center, Marquette 49855

MASON
William F. Sutter, MD, 220 S. James, Ludington 49431
Robert L. Ewing, MD, 603 E. Tinkham, Ludington 49431

MECOSTA-OSCEOLA-LAKE
James L. Tyson, MD, 1014 South State Street, Big Rapids 49307
Leland A. Hickox, MD, 1014 South State St., Big Rapids 49307

MENOMINEE
William S. Jones, Jr., MD, 1146 10th Avenue, Menominee 49858
Herman R. Brukardt, MD, 534 First Street, Menominee 49858

MIDLAND
V. A. Marks, MD, 2706 Louanna, Midland 48640
Charles A. Willison, MD, 122 Townsend, Midland 48640

MONROE
S. Newton Kelso, Jr., MD, 116 Cole Rd., Monroe 48161
Bernard Sisman, MD, 130 Cole Rd., Monroe 48161

MUSKEGON
H. Clay Tellman, MD, 302 Medical Arts Center, Muskegon 49441
Clarence A. Vandervelde, MD, 1470 Peck Street, Muskegon 49441

(Continued on Page 842)

What is worth doing...

In 1936 A. E. Smith, professional at Woolcombe, England, recorded the lowes golf score for an 18 hole course. He shot 55 and was 15 under par. The course at Woolcombe, which measured 4,248 yards was covered in 4, 2, 3, 4, 2, 4, 3, 4, 3 out and 2, 3, 3, 3, 3, 2, 5, 4, 1 in.

s worth doing well.

Take ACHROMYCIN V, for example. Lederle routinely runs over 1,000 quality control checks on every batch produced. Many, many more than officially required. This extra attention means your patients get what the doctor ordered when you prescribe ACHROMYCIN V: uniform *in vitro* dissolution rate, predictable *in vivo* serum and urinary levels. In short, known biologic availability of tetracycline. And every step in the production of ACHROMYCIN V is

in-house controlled right in Pearl River.

ACHROMYCIN®-V
Tetracycline HCl

Performance proved in practice

ctiveness: ACHROMYCIN acycline is a crystalline broad-ctrum antibiotic which provides ctive therapeutic activity against ceptible microorganisms.
traindication: History of ersensitivity to tetracycline.
ning: In renal impairment, usual es may lead to excessive umulation and liver toxicity. Under conditions, lower than usual doses ndicated and, if therapy is onged, serum level determinations be advisable. Some patients may elop a photodynamic reaction to ral or artificial sunlight. Those with a ory of photosensitivity reactions ld avoid direct exposure to sunlight e under treatment. Discontinue drug rst evidence of skin discomfort.
cautions: Use may result in rgrowth of nonsusceptible organisms. Constant observation is essential. If new infections appear, take appropriate measures. Use of tetracycline during teeth development may cause discoloration of teeth.
Side Effects: Gastrointestinal system—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. Skin—maculopapular and erythematous rashes (a case of exfoliative dermatitis has been reported); photosensitivity reaction, onycholysis and discoloration of nails (rare). Kidney—rise in BUN, apparently dose-related. Hypersensitivity reactions—urticaria, angioneurotic edema, anaphylaxis. In young infants, bulging fontanels have been reported following full therapeutic dosage. This symptom has disappeared rapidly when drug is discontinued. Teeth—dental staining (yellow-brown) in children of mothers given tetracycline during the latter half of pregnancy, and in children given the drug during the neonatal period, infancy and early childhood. Enamel hypoplasia has been seen in a few children. Blood—anemia, thrombocytopenic purpura, neutropenia, eosinophilia. Liver—cholestasis (rare), usually at high dosage. Tetracycline may form a stable calcium complex in bone-forming tissue. If adverse reaction or idiosyncrasy occurs, discontinue medication and institute appropriate therapy.
Average Adult Daily Dosage: One Gm. per day, in 4 divided doses of 250 mg. each. Should be given 1 hour before or 2 hours after meals, since absorption is impaired by the concomitant administration of high calcium content drugs, foods and some dairy products. Treatment of streptococcal infections should continue for 10 days, even though symptoms have subsided.

derle LEDERLE LABORATORIES, A Division of American Cyanamid Company, Pearl River, New York 10965

281-0

Howard V. Sanden, MD, 1643 Peck St., Muskegon 49441
Donald P. Stratton, MD, 3535 Park St., Musekgon 49441
Robert E. Smith, MD, 212 Medical Arts Center, Muskegon 49441
Austin A. Aardema, MD, 1470 Peck, Muskegon 49441

NEWAYGO
J. Paul Klein, MD, 16 West Sheridan, Fremont 49412
Robert E. Paxton, MD, 220 W. Pine, Fremont 49412

NORTH CENTRAL
Charles L. Oppy, MD, Roscommon 48653
Lloyd T. Wiegerink, MD, West Branch 48661

NORTHERN MICHIGAN
Jack R. Postle, MD, Burns Clinic, Petoskey 49770
Richard A. Kutciple, MD, 211 Sunset, Petoskey 49770

OAKLAND
Paul T. Lahti, MD, 3600 West 13 Mile Rd., Royal Oak 48072
Harold A. Furlong, MD, 35 S. Johnson St., Pontiac 48053
Richard R. Galpin, MD, 525 Southfield Rd., Birmingham 48009
Zachary F. Endress, M.D., 1790 Tiverton Rd., Bloomfield Hills 48013
John H. McLaughlin, MD, 604 N. Woodward Avenue, Birmingham 48011
Shelby M. Baylis, MD, 35 S. Johnson Street, Pontiac 48053
Worth W. Henderson, MD, 1307 S. Washington Avenue, Royal Oak 48067
Edward E. Elder, Jr., MD, 1116 Vorheis Road, Pontiac 48054
Carl H. Birkelo, MD, 4680 Dixie Highway, Drayton Plains 48020
Arnold L. Brown, MD, 35 S. Johnson Street, Pontiac 48053
Bruce D. Bauer, MD, 3229 Woodward Avenue, Berkley 48072
James A. Read, MD, 610 N. Woodward Ave., Birmingham 48011
John B. Bryan, MD, 4045 West 13 Mile Road, Royal Oak 48072
Kenneth L. Urwiller, MD, 909 Woodward Ave., Pontiac 48053
Robert L. Tupper, MD, 86 Ottawa Drive, Pontiac 48053
Charles R. Sempere, MD, 35 S. Johnson St., Pontiac 48053
Edwin J. Westfall, MD, 3535 West 13 Mile Rd., Royal Oak 48072
John R. Lichtwardt, MD, 3535 West 13 Mile Rd., Royal Oak 48072
Henry L. Jenkins, MD, 161 State Street, Pontiac 48053
Ben Gaber, MD, 10831 West 10 Mile Rd., Oak Park 48237
E. William Bauer, MD, 3229 Woodward Avenue, Berkley 48072
Keith M. Holmes, MD, 880 Woodward Ave., Pontiac 48053
Thomas G. Varbedian, MD, 195 W. Brown St., Birmingham 48011
John A. Ingold, MD, 3535 West 13 Mile Rd., Royal Oak 48072
William R. Rech, MD, 2335 S. Commerce Rd., Walled Lake 48088

OCEANA
John J. Vrbanac, MD, 601 E. Main, Hart 49420
Willis A. Hasty, MD, 204 N. Michigan, Shelby 49455

ONTONAGON
James P. Strong, MD, R.R. 1, Box 406, Ontonagon 49953
Carl R. Lahti, MD, Rt. 2, Ontonagon 49953

OTTAWA
William Rottschaefer, MD, 601 Michigan Avenue, Holland 49423
Frank L. Groat, MD, 631 Franklin St., Grand Haven 49417
Alvin Bonzelaar, MD, 144 W. 26th St., Holland 49423

SAGINAW
Vernon V. Bass, MD, 3322 Davenport St., Saginaw 48602
Roy J. Gerard, MD, 2419 Mackinaw, Saginaw 48602
Duane B. Heilbronn, MD, 1703 N. Michigan Avenue, Saginaw 48602
Robert J. Toteff, MD, 2110 Morson Street, Saginaw 48602
Jack L. Barry, MD, 4670 Dixie Highway, Saginaw 48601
William A. DeYoung, MD, 1100 So. Washington Ave., Saginaw 48601
Robert E. Jardinico, MD, 206 S. Webster, Saginaw 48601
Harry C. Matthews, MD, 1227 N. Michigan Avenue, Saginaw 48601

ST. CLAIR
Charles N. Hoyt, MD, 2928 Pine Grove, Port Huron 48060
Daniel J. Wilhelm, MD, 619 River Street, Port Huron 48060
Harry E. Mayhew, MD, 640 N. 3rd, St. Clair 48079
Gordon H. Webb, MD, 875 Michigan Avenue, Marysville 48040

ST. JOSEPH
Robert H. Evans, MD, 111 So. Monroe, Sturgis 49091
Robert D. Smith, MD, Colon 49040

SANILAC
Keate T. McGunegle, MD, Sandusky 48471
Raymond J. Winfield, MD, 3014 Main St., Marlette 48543

SHIAWASSEE
Henry T. Forsyth, MD, 137 S. Saginaw, Chesaning 48616
William J. A. Ford, Jr., MD, 113 E. Williams St., Owosso 48867

TUSCOLA
Herbert L. Nigg, MD, 206 Montague, Caro 48723
Edward J. Miles, MD, 206 Montague, Caro 48723

VAN BUREN
David J. Millard, MD, 305 Oak, Paw Paw 49079
James M. Davis, MD, 424 Huron, South Haven 49090

WASHTENAW
Henry A. Scovill, MD, 1313 West Cross, Ypsilanti 48197
Stuart M. Gould, Jr., M.D., Mercywood Hospital, Ann Arbor 48106
John W. Henderson, MD, C6264 University Medical Center, Ann Arbor 48104
Beverly C. Payne, MD, 425 East Washington St., Ann Arbor 48108
Robert J. Fisher, MD, 750 Towner, Ypsilanti 48197
Clarence E. Crook, MD, St. Joseph Mercy Hospital, Ann Arbor 48104
Harold F. Falls, MD, C6264 University Medical Center, Ann Arbor 48104
Harry A. Towsley, MD, W5610 University Medical Center, Ann Arbor 48104
Neal A. Vanselow, MD, D3147 University Medical Center, Ann Arbor 48104
Howard R. Williams, MD, 1950 Medford, Ann Arbor 48104
Joseph C. Cerny, MD, C5215 University Medical Center, Ann Arbor 48104
Robert M. Oneal, MD, 555 East Williams, Ann Arbor 48104
William R. Rekshan, MD, 425 East Washington, Ann Arbor 48108
David W. Schmidt, MD, 1230 Maple Road, Ann Arbor 48103
Lyle D. Elliott, MD, 750 Towner, Ypsilanti 48197
Alexander Gotz, MD, 2201 Medford Rd., Ann Arbor 48104
George H. Koepke, MD, E3127 University Medical Center, Ann Arbor 48104
Edwin H. Place, MD, 2616 Hawthorne Rd., Ann Arbor 48104
Richard D. Watkins, MD, Mercywood Hospital, Ann Arbor 48106

WAYNE COUNTY
Robert K. Whiteley, MD, 608 Eastland Professional Building, Detroit 48225
Homer M. Smathers, MD, 17620 W. McNichols, Detroit 48235
Ned I. Chalat, MD, 1553 Woodward Avenue, Detroit 48226
James D. Fryfogle, MD, 15901 W. 9 Mile Road #715, Southfield 48075
James C. Danforth, Jr., MD, 20175 Mack Avenue, Grosse Pointe Woods 48236
James B. Blodgett, MD, 3535 W. 13 Mile Rd., #406, Royal Oak 48072
Sidney Adler, MD, 3011 W. Grand Boulevard, Detroit 48202
Donald N. Sweeny, Jr., MD, 8445 E. Jefferson, Detroit 48214
Marjorie Peebles-Meyers, MD, 3790 Woodward, Detroit 48201
Brock E. Brush, MD, 2799 W. Grand Boulevard, Detroit 48202

Ralph R. Cooper, MD, 1515 David Whitney Building, Detroit 48226
Frank B. Bicknell, MD, 938 David Whitney Building, Detroit 48226
Edward J. Tallant, MD, 18041 Greenfield, Detroit 48235
Paul J. Connolly, MD, 3800 Woodward Avenue, Detroit 48201
John W. Moses, MD, Mt. Carmel Mercy Hospital, 6071 Outer Drive, W., Detroit 48235
Louis E. Heideman, MD, 3800 Woodward Avenue, Detroit 48201
Luther R. Leader, MD, 3535 W. 13 Mile Road, Royal Oak 48072
Charles E. Darling, MD, 673 Fisher Building, Detroit 48202
Alexander Blain, III, MD, 2201 E. Jefferson, Detroit 48207
A. Martin Lerner, MD, 1400 Chrysler Expressway, Detroit 48207
Robert H. Hamburg, MD, 1515 David Whitney Building, Detroit 48226
George Mogill, MD, 3150 Second Boulevard, Detroit 48201
Raymond J. Barrett, MD, 3800 Woodward # 1202, Detroit 48201
C. Jackson France, MD, 17800 East 8 Mile Road # 436, Harper Woods 48225
Francis P. Rhoades, MD, 2414-16 Broderick Tower, Detroit 48226
James M. Kennary, Jr., MD, 4900 Cadieux Road, Detroit 48224
Benjamin Jeffries, MD, 19959 Vernier Rd., Harper Woods 48236
Sidney E. Chapin, MD, 125 N. Military, Dearborn 48124
Kenneth L. Krabbenhoft, MD, 3825 Brush St., Detroit 48201
Conrad R. Lam, MD, Henry Ford Hospital, Detroit 48202
Robert D. Allaben, MD, 18255 W. McNichols Rd., Detroit 48219
Irvin A. Wilner, MD, 17701 West McNichols Rd., Detroit 48235
George F. Porretta, MD, 15901 W. Nine Mile Road, Southfield 48075
Arthur Z. Ostrowski, MD, 610 Northland Medical Building, Southfield 48075
James M. Pierce, Jr., MD, Wayne State University, Detroit 48202
Gerald H. Mandell, MD, Sinai Hospital, Detroit 48235
Joseph A. Witter, MD, 134 W. University Drive, # 304, Rochester 48063
Lee E. Feldkamp, MD, 306 North Main, Plymouth 48170
Thomas M. Flake, MD, 13800 Livernois Avenue, Detroit 48238
H. Ross Hume, Jr., MD, 3800 Woodward Avenue, # 406, Detroit 48201
Marshall J. Blondy, MD, 19009 West 7 Mile Road, Detroit 48219
Homer A. Howes, MD, 1515 David Whitney Building, Detroit 48226
Leon Rottenberg, MD, 13419 Fenkell Avenue, Detroit 48227
William J. Yott, MD, 854 Lakeshore Road, Detroit 48236
Eli J. Igna, MD, 2799 W. Grand Boulevard 48202
Hershel Sandberg, MD, 19207 Schaefer, Detroit 48235
Henry M. Domzalski, MD, 15252 Gratiot Avenue, Detroit 48205
Arthur B. Levant, MD, 15715 E. Warren, Detroit 48224
Joseph L. Ponka, MD, 2799 W. Grand Boulevard, Detroit 48202
Reuben I. Shapiro, MD, 22341 W. 8 Mile Road, Detroit 48219
Fred E. Caumartin, MD, 17184 Wildemere, Detroit 48221
Eugene L. Freitas, MD, St. Johns Hospital, Detroit 48236
Louis R. Zako, MD, 7720 Allen Road, Allen Park 48101
Frank B. Walker, II, MD, 1206 Balfour Road, Grosse Pointe Park 48230
Richard S. Kamil, MD, 14438 W. McNichols, Detroit 48235
Herbert A. Raskin, MD, 20100 W. 10½ Mile Rd., Southfield 48075
Ralph H. Pino, MD, 31841 Kingswood Square, Farmington 48024
Richard L. Lamont, MD, 3815 Pelham Road, Dearborn 48124
Arthur A. Ulmer, MD, 79 Greenbriar, Grosse Pointe Shores 48236

Increase Practice Control Through MANAGEMENT By

OBJECTIVES

Modern office and financial management offers realistic methods toward achievement of personal life goals. A logical outcome of PM's services is the attainment of your objectives.

- More Time for Patient
- More Time for Leisure
- Better Collection Control
- Better Cost Control
- Assistance With Financial Planning
- Identify Business Problems
- Seek Best Solutions to Problems

PROFESSIONAL MANAGEMENT FOR PHYSICIANS AND DENTISTS
since 1932
PM®

PROFESSIONAL MANAGEMENT
Black and Skaggs Associates, Inc.
Battle Creek, Michigan

Serving Michigan Physicians

Offices in these cities
Ann Arbor - Battle Creek - Berkley - Detroit - Flint
Grand Rapids - Lansing - Muskegon - Saginaw - Traverse City

Frederick Weissman, MD, 20905 Greenfield Road, Southfield 48075
Walter F. Kujawski, MD, 17800 E. Eight Mile Road, Detroit 48236
Paul R. Dumke, MD, 2799 W. Grand Boulevard, Detroit 48202
Alexander H. Hirschfeld, MD, 3790 Woodward, Detroit 48201
Albert J. Albrecht, MD, 4407 Roemer, Dearborn 48126
Joseph O. Reed, Jr., MD, 448 Lincoln, Detroit 48230
John W. Moynihan, MD, 2841 Monroe Boulevard, Dearborn 48124
Richard D. Anslow, MD, 1515 David Whitney Building, Detroit 48226
John Gilroy, MD, Harper Hospital, Detroit 48201
Walter L. Anderson, MD, 1553 Woodward Avenue, Detroit 48226
Vincent J. Gallant, MD, 1414 Wellesley Drive, Detroit 48203
Charles J. Holt, Jr., MD, 1210 South Oxford, Grosse Pointe 48236
Michael N. Zelenock, MD, 15830 Fort, Southgate 48192
Elden C. Baumgarten, MD, 1062 Lochmoor Boulevard, Grosse Pointe Woods 48236
Kenneth J. Ray, MD, 28059 Elba Drive, Grosse Ile 48138
John F. Cotant, MD, 15901 W. 9 Mile Road # 420, Southfield 48075
Robert C. Thumann, Jr., MD, 20045 Mack Avenue, Grosse Pointe Woods 48236
Earl E. Weston, MD, 18101 James Couzens Hwy., Detroit 48235
Paul M. Zavell, MD, 92 Moran Road, Grosse Pointe Farms 48236
Raymond J. Kokowicz, MD, 19440 Van Dyke, Detroit 48234
Donald W. Visscher, MD, 12922 W. Warren, Dearborn 48126
Donald I. Bryan, MD, 15901 W. 9 Mile Road, Southfield 48075
Alfred Golden, MD, 26764 York Road, Huntington Woods 48070
Thomas Ganos, MD, 6742 Park Avenue, Allen Park 48101
Lee B. Stevenson, MD, 22812 Walsingham Road, Farmington 48024
Joseph J. Woods, MD, 2022 Washtenaw Road, Ypsilanti 48197
Myron H. Joyrich, MD, Sinai Hospital, Detroit 48235
Everal M. Wakeman, MD, 155 South Denwood, Dearborn 48124
Andrew R. W. Climie, MD, Harper Hospital, Detroit 48201
Robert E. McKnight, MD, 15901 W. 9 Mile Road, Southfield 48075
Arthur Goldberg, MD, 20461 John R. Street, Detroit 48203
Waldo L. Cain, MD, 3800 Woodward Avenue, # 804, Detroit 48201
Gilbert M. Bazil, MD, 14200 Puritan, Detroit 48227
James R. Lloyd, MD, 1515 David Whitney Building, Detroit 48226
Frederick W. Hyde, Jr., MD, Grace Hospital, Detroit 48201
William A. Willoughby, MD, 974 Fisher Building, Detroit 48202
Louis F. Hayes, MD, 441 E. Jefferson, Detroit 48226
James E. Kermath, MD, 15101 Southfield, Allen Park 48101
Clayton M. Shors, MD, 20861 Mack, Grosse Pointe Woods 48236
E. Clarkson Long, MD, 19751 James Couzens Hwy., Detroit 48235
William G. Bentley, MD, 50 Westminster, Detroit 48202
William G. McDonald, MD, 15600 Michigan Avenue, Dearborn 48126
Andrew J. Hopkins, MD, 4407 Roemer, Dearborn 48126
James P. Gallagher, MD, 14801 Southfield, Allen Park 48101
Raymond D. Sphire, MD, 1420 St. Antoine, Detroit 48226
Lawrence J. McNichol, MD, 18424 W. McNichols Rd., Detroit 48219
Robert A. Gerisch, MD, 1217 David Whitney Building, Detroit 48226
John J. Siller, MD, 17000 W. 8 Mile Road, Southfield 48075
Lincoln E. Solberg, MD, 2021 Monroe, Dearborn 48124
Ralph C. Rueger, MD, 3399 Daleview Drive, Ann Arbor 48103
John M. Shuey, MD, 17198 Oak Drive, Detroit 48221
Jean M. Holdredge, MD, 3011 West Grand Boulevard, Detroit 48202
I. Walter Silver, MD, 20000 West Chicago, Detroit 48228
Samuel I. Lerman, MD, 18330 Parkside, Detroit 48221
Frank L. Harrington, MD, 15901 W. 9 Mile Road, Southfield 48075
Eugene J. Cetnar, MD, 4322 Bishop, Detroit 48224
Robert C. Douglass, MD, 23023 Orchard Lake Road, Farmington 48024

WEXFORD-MISSAUKEE
Dennis E. Van Alst, MD, 828 Oak Street, Cadillac 49601
John P. Cannon, MD, 107½ N. Mitchell St., Cadillac 49601

SECTION DELEGATES AND ALTERNATES FOR THE MSMS HOUSE OF DELEGATES

ALLERGY AND APPLIED IMMUNOLOGY
James A. McLean, MD, 1313 E. Ann St., Ann Arbor 48103
Jack E. Goodwin, MD, 1600 No. Mich. Ave., # 301, Saginaw 48602

ANESTHESIOLOGY (MICHIGAN SOCIETY OF ANESTHESIOLOGISTS, INC.)
Bernard J. Sivak, MD, 24665 Santa Barbara, Southfield 48075
John D. Snider, MD, 1827 Argentina Dr., SE, Grand Rapids 49506

DERMATOLOGY
Robert J. Schoenfeld, MD, 800 So. Adams Rd., Birmingham 48011
Richard J. Ferrara, MD, 20045 Mack Ave., Grosse Pointe Woods 48236

GASTROENTEROLOGY
Ramon R. Joseph, MD, Wayne Co. Gen. Hospital, Eloise 48132
Abner I. Pagins, MD, 909 Woodward Ave., Pontiac 48053

GENERAL PRACTICE
Douglas A. Haddock, Jr., MD, 6646 Portage St., Kalamazoo 49002
James F. Dooley, MD, 3210 S. Dort Highway, Flint 48507

INTERNAL MEDICINE
William B. McIntyre, MD, 20901 Moross Rd., Detroit 48236
Klaus P. Schmidt, MD, 871 Fisher Bldg., Detroit 48202

NEUROLOGY
Mark C. Levine, MD, G3083 Flushing Rd., Flint 48504
James Dana Darnley, MD, 26711 Woodward Ave., Huntington Woods 48070

MICHIGAN ASSOCIATION OF NEUROLOGICAL SURGEONS (Section on Neurological Surgery)
H. Harvey Gass, MD, 529 Fisher Bldg., Detroit 48202
Philip H. Hoekstra, MD, 909 Fulton St., E., Grand Rapids 49503

OBSTETRICS-GYNECOLOGY
Roger W. Postmus, MD, 662 Wembly Ct., Ann Arbor 48103
Harrison C. Visscher, MD, 515 Lakeside Dr., SE, Grand Rapids 49506

OCCUPATIONAL MEDICINE (MICHIGAN INDUSTRIAL MEDICINE ASSOCIATION)
Benjamin B. Holder, MD, Box 469, Midland 48640
Not elected

OPHTHALMOLOGY
Fleming A. Barbour, MD, 2015 Lincoln Drive, Flint 48504
Glenn E. Mohney, MD, 1131 Erie St., Port Huron 48060

ORTHOPEDIC SURGERY
John O. Goodsell, MD, 1600 N. Michigan, Saginaw 48602
Perry W. Greene, Jr., MD, 515 Lakeside Drive, SE, Grand Rapids 49506

OTOLARYNGOLOGY
Frank N. Ritter, MD, 2675 Englave Dr., Ann Arbor 48103
John W. Grigg, MD, 515 Mulholland St., Bay City 48706

PATHOLOGY (MICHIGAN SOCIETY OF PATHOLOGISTS)
Leo W. Walker, MD, St. Lawrence Hospital, Lansing 48914
Edwin M. Knights, Jr., MD, Providence Hospital, 16001 W. 9 Mile Rd., Southfield 48075

PEDIATRICS
Wilfred S. H. Nolting, MD, 15851 E. Warren Ave., Detroit 48224
William F. Howatt, MD, University Hospital, Ann Arbor 48104

PHYSICAL MEDICINE
Jack R. Grommons, MD, 721 W. Sixth Ave., Flint 48503
Joseph N. Schaeffer, MD, 261 Mack Blvd., Detroit 48201

PLASTIC SURGERY
Alexander P. Kelly, MD, Henry Ford Hospital, Detroit 48202
David B. Hawtof, MD, 15901 W. Nine Mile Rd., Southfield 48075

PROCTOLOGY
Donald J. Pearson, MD, 255 North Avenue, Battle Creek 49017
Robert E. McKnight, MD, 15901 W. 9 Mile Rd., Southfield 48075

PSYCHIATRY
Stephen C. Mason, III, MD, 820 E. University, Ann Arbor 48014
Warren S. Wille, MD, 5325 Brown Lake Rd., Jackson 49203

PUBLIC HEALTH & PREVENTIVE MEDICINE
Winston B. Prothro, MD, 1619 Walker St., NW, Grand Rapids 49504
Leland C. Brown, MD, 21536 Parkway, St. Clair Shores 48082

RADIOLOGY
Robert A. Songe, MD, Oakwood Hospital, Dearborn 48121
Clarence P. Chrest, MD, 458 W. South St., Kalamazoo 49006

SURGERY
Michael N. Zelenock, MD, 15830 Fort, Southgate 48192
Not elected

THORACIC SURGERY (MICHIGAN SOCIETY OF THORACIC SURGEONS)
Forest D. Dodrill, MD, 641 David Whitney Bldg., Detroit 48013
Conrad R. Lam, MD, Henry Ford Hospital, Detroit 48202

UROLOGY (DETROIT BRANCH AMERICAN UROLOGICAL SOCIETY)
David Siegel, MD, 2909 E. Grand River, Lansing 48912
Sherwin J. Lutz, MD, 15121 W. McNichols, Detroit 48235

Eighteenth Pharmacopeia Now Published

U.S. P. XVIII, the completely revised new Pharmacopeia, was published in April and will become effective Sept. 1. More drugs and dosage forms are recognized in this eighteenth revision than have been listed before in any modern U.S. Pharmacopeia.

The Pharmacopeia continues to provide standards and tests for demonstrating the strength, purity and quality of drugs. A total of 1,103 Monographs, among them 847 carried over from the 904 titles official in the preceding edition, are included in U.S.P. XVIII.

Scientific Papers, Reports Presented at 1870 MSMS Annual Meeting

The Annual Meeting of the Michigan State Medical Society of 1870 — one hundred years ago — was held in Lansing on June 8 and 9.

In addition to annual matters of business, the physicians listened to a series of scientific papers. The titles and speakers included:

"State Care of the Insane"
— By Wm. Brodie, M.D., Detroit

"Contagiousness of Typhoid Fever"
— By G. W. M. Topping, M.D., DeWitt

"Dysentery: Its Peculiarities and Treatment"
— By Chas. T. Southworth, M.D.

"Electrical Springs: Their Nature and Value as Curative Agents"
— By H. B. Shank, M.D., Lansing

"Large Fibrous Nasal Polypus"
— By H. O. Hitchcock, M.D., Kalamazoo

"Puerperal Convulsions"
— By Wm. Parmenter, M.D., Vermontville

"Amputations and the Treatment of Stumps"
— By Theodore A. McGraw, M.D., Detroit

"Physical Biology: A Philosophy of Life"
— By H. B. Baker, M.D., Wenona

"Sympathetic Ophthalmia"
— By J. F. Noyes, M.D., Detroit

"Menstruation without Ovulation"
— By Edward W. Jenks, M.D., Detroit

"Krameriaceae: Phatany Roots"
— By J. M. Bigelow, M.D., Detroit

"A Case of Hydrocephalus, Terminating in Death in a Child Aged Two Years, Three Months and Four Days"
— By Geo. E. Ranney, M.D., Lansing

The "Annual Address of the President" was given by Richard Inglis, M.D., Detroit. I. H. Bartholomew, M.D., was elected as the new president for 1870-71.

Committees which reported at the annual meeting included:

"Committee on Excision of the Hip Joint for Morbus Coxarius"
— By Henry F. Lyster, M.D., Detroit, Chairman

"Committee on Registration of Physicians"
— Edward W. Jenks, M.D., Detroit, Chairman

"Committee on Remedial Substitutes for Blood-Letting"
— William H. DeCamp, M.D., Grand Rapids, Chairman

Make a Point to Visit These Firms' Educational Exhibits at MSMS Annual Session

Michigan physicians who walk down the "midway" of colorful and educational exhibits at the 1970 MSMS Annual Session Sept. 20-24 in Detroit will find 55 firms represented.

The state-wide, national and international companies will showcase products and techniques ranging from complicated laboratory equipment to baby food, and all of them pertinent to a doctor's practice.

The physician who takes time to study the materials at each booth will find the minutes well spent, for much new research and refinement of knowledge will be represented. Time to visit the exhibits will be available between short meetings and during special intermissions in the more lengthy courses. The registration desk, meeting rooms and exhibits will be conveniently located on the same floor.

The leasing of exhibit space makes it possible for MSMS to present the two-day Annual Scientific Session free of charge to the doctor, without requirement of a registration fee.

MSMS wishes to express its gratitude to those who have generously made program grants to the Annual Scientific Session. These contributors are **Geigy Pharmaceuticals** and **Warner-Chilcott Laboratories.**

Following is a list of the firms who will be presenting displays. Doctors are urged to ask questions and to personally express appreciation to the exhibitors at each booth.

Abbott Laboratories
Ames Company, Inc.
Apache Corporation
Astra Pharmaceutical Products
Ayerst Laboratories
Bio-Med Laboratories
Breon Laboratories, Inc.
Bristol Laboratories
Brookes Research Associates
Burroughs Wellcome & Co. (USA) Inc.
Carnation Company
Ciba Pharmaceutical Products, Inc.
Coca-Cola USA
Continental Bio-Clinical Laboratory Service
Cooper Laboratories, Inc.
Eaton Laboratories, Inc.
Thomas A. Edison Industries
The Emko Company
Encyclopaedia Britannica
Ferndale Laboratories, Inc.
Gerber Products Company
Hack Shoe Company
Lederle Laboratories
Len-Tag Company
Eli Lilly & Company
J. B. Lippincott Company
Maico Hearing
Marion Laboratories, Inc.
Mead Johnson Laboratories
Medical Protective Company
Medi-Comp Associates, Inc.
Merck Sharp & Dohme
Michigan Association of Collection Agencies
Michigan Bell Telephone Co.
Michigan Medical Service
North American Pharmacal
Organon Inc.
Ortho Pharmaceutical Corp.
Parke, Davis & Company
Pfizer Laboratories
Professional Management
A. H. Robins Company, Inc.
J. B. Roerig & Company
Wm. H. Rorer, Inc.
Ross Laboratories
Sandoz Pharmaceuticals
W. B. Saunders Company
Schering Corporation
G. D. Searle & Company
Seven-Up Developers of Michigan
Smith Kline & French Laboratories
E. R. Squibb & Sons
Standard Process Laboratories
Ben P. Stratton Agency, Inc.
The Stuart Company
Thompson Laboratories, Inc.
S. J. Tutag & Company
Warren-Teed Products Company
Westwood Pharmaceuticals
Winthrop Laboratories, Inc.
Wyeth Laboratories

in memoriam

Watson Beach, M.D.
Grosse Pointe Woods

Watson Beach, M.D., retired Grosse Pointe surgeon, died June 21 at the age of 73.

A former head of the Anatomy Department at Wayne State University School of Medicine, Doctor Beach was a graduate of the Detroit College of Medicine and Surgery.

He was a fellow in surgery in the Mayo Graduate School of Medicine from 1924 to 1928, when he left for Detroit. He was affiliated with the staffs of Detroit Receiving, Providence, St. Johns, Saratoga General, Bon Secours and Cottage Hospitals in the Detroit area.

Doctor Beach was a fellow of the American College of Surgeons.

Kenneth N. Campbell, M.D.
Bloomfield Hills

Kenneth Norman Campbell, M.D., Detroit physician, researcher and teacher, died June 25 at the age of 57. He resided in Bloomfield Hills.

Doctor Campbell was on the staffs of five Detroit hospitals and was the first surgeon in Detroit to perform several types of surgery, including aortic grafts and re-implantation of limbs. He was the author of research papers on such subjects as plastic surgery, burns, vascular diseases, protein therapy, shock anesthesia and renal function.

Doctor Campbell was graduated from Wayne State University School of Medicine and was a former assistant professor of surgery at the University of Michigan. He was a fellow of the American Board of Surgery and the American College of Surgeons and belonged to the American Federation of Clinical Research, the Detroit Surgical Society and American Society of Abdominal Surgeons.

Clarence M. Clark, M.D.
Detroit

Clarence M. Clark, a life member of the Wayne County Medical Society, died June 12 at the age of 76.

Doctor Clark was graduated from the Detroit College of Medicine and Surgery and began practice in Detroit in 1915. A general practitioner, he was affiliated with the former St. Marys and St. Francis Hospitals. He was a member of the Association of Physicians and Surgeons.

Arthur C. Curtis, M.D.
Ann Arbor

Arthur C. Curtis, M.D., professor emeritus of dermatology at the University of Michigan, died July 7 at the age of 72.

Doctor Curtis served as chairman of the U-M Department of Dermatology from 1946 until 1967, when he retired. He had since been in private practice at the U-M Medical Center. A graduate of the University of Michigan Medical School, he was appointed assistant to the dean in 1928 and served as secretary from 1931 to 1935.

Doctor Curtis was a past president of the Detroit Dermatological Society, the AMA Section on Dermatology, the American Academy of Dermatology and Syphilology, and the American Venereal Disease Association.

He was the recipient in 1966 of a MSMS Certificate of Commendation, being cited at that time for his distinguished career in internal medicine.

(Continued on Page 849)

2,000 LIMITED PARTNERSHIP UNITS
IN MULTIVEST
REAL ESTATE FUND, LTD.
$2,500 Per Unit

The Partnership intends to invest its funds in real properties which the General Partner considers will offer a potential for profit either through the production of income or through gain on resale. Secondarily, when feasible within these objectives, the Partnership will also attempt to provide tax shelter for participants. At least 90% of investments will be in existing income producing real estate.

This announcement is neither an offer to sell nor a solicitation of an offer to buy these securities. This offer is made only by the prospectus in states where authorized, in compliance with state requirements. The Prospectus may be obtained from Multi-Vest Real Estate, Inc., or an authorized security dealer in any state where such offer may lawfully be made.

MultiVest Real Estate, Inc.

Mail Coupon Today or Call (313)352-3100
P.O. Box 550, Southfield, Michigan 48075
Gentlemen:
Please send me the free prospectus concerning MultiVest Real Estate Fund, Ltd.
NAME ____________________
ADDRESS ____________________
CITY __________ STATE __________ ZIP ______
PHONE NO: ____________________ MedA

Classified Advertising

$5.00 per insertion of 50 words or less, with an additional 10 cents per word in excess of 50.

INTERNIST needed for established multi-specialty group in Detroit. Excellent professional relationship. Reply: Box 14, 120 W. Saginaw Street, East Lansing, Michigan 48823.

PSYCHIATRISTS: Avoid pollution — enjoy fresh air, clean water, less people in summer-winter vacationland near Interlochen Arts Academy. Small town peace and quiet. Big City culture and salaries. Progressive psychiatric hospital, JCAH approved, 3 year psychiatric residency program. Salaries to $32,364 if you qualify, excellent fringes, housing available. Contact M. Duane Sommerness, M.D., Traverse City State Hospital, Traverse City, Michigan 49684.

FAMILY PRACTICE PHYSICIANS — Board of Trustees of St. Mary's Hospital in Marquette invites family practice physicians to practice in Michigan's upper peninsula. This community has two hospitals, excellent schools, churches and year-round sports activities. This hospital is a 126 bed modern, well equipped, JCAH accredited general hospital including psychiatric and rehabilitation units in which to practice professional skills. Interested physicians may contact: Archie S. Narotzky, M.D., Chief of Staff, St. Mary's Hospital, Marquette, Michigan 49855.

ANN ARBOR–YPSILANTI AREA. 3 yr. AMA approved, university affiliated psych. residency at mental health center offering comprehensive services to SE Mich. Teaching faculty & supervisors include U. of M. faculty, private psychiatrists & analysts, as well as hospital staff. Resident's time divided approx. equally between didactic seminars (including supervision) & clinical experience. First year ADM & Intensive Treatment Units; second & third year assigned Community Psych. and/or OPC and/or Children's unit. Additional experience in psychosomatic medicine, Univ. Mental Hygiene Clinic, and neurology. 3-year: $11,358 to $12,924. 5-yr: $12,945 to $23,197. $15,000 NIMH grants & dependency allowance ($500 per) available to eligible physicians in practice 4+ years. Contact: J. Tiziani, M.D., Ypsilanti State Hospital, Ypsilanti, Michigan 48197.

RADIOLOGIST, full-time, for accredited hospital in Detroit. Excellent remuneration. Reply to Box 16, 120 West Saginaw Street, East Lansing, Michigan 48823.

LOCUM TENENS: Doctor wanted for relief coverage of general practitioner for one to six months. Opportunity to continue association is open. Salary $2,000 per month. Contact: H. A. Timreck, M.D., 230 E. Cedar Street, Gladwin, Michigan 48624. Phone: (517) Office 426-9225, Home 426-9233.

SEMI-RETIRE IN FLORIDA!! Clean air, fishing and beaches. Emergency room physicians needed full time for expanding Florida Hospital. Must have Florida license and qualify for Active Staff privileges. Fee for service with guarantee of $219.00 per 25 hour week. No overhead. Hospital does billing of fees at no expense to you. Write E. Gilbert Slatton, Administrator, Wuesthoff Memorial Hospital, Rockledge, Florida 32955.

WANTED: Internist to join two man partnership in Michigan's upper thumb area. Excellent recreation and educational facilities are available. Write to: K. B. Herrington, M.D. or Kenneth S. Kube, M.D., 669 South Van Dyke, Bad Axe, Michigan. May call collect: (517) 269-6453.

EXTREMELY BUSY two man group needs OB man, who is willing to do some general practice, or a GP who particularly wants to do OB. New modern 80 bed hospital with CCU unit. Small town in Northern Michigan, serving an area of about 12,000 people. Office space available, and financial arrangements entirely open to discussion. P.C. possible. Write Box 12, 120 West Saginaw Street, East Lansing, Michigan 48823, or phone (517) 846-6122.

WANTED: General Practitioner to associate with G. P. Surgeon in well established practice. Town of 2500, service area of 25,000. New open staff hospital. Salary $25,000 with early partnership opportunity. Excellent recreational area, good schools, community college, all churches. Exceptional opportunity. Contact: H. A. Timreck, M.D., 230 E. Cedar Street, Gladwin, Michigan 48624. Phone: (517) Office 426-9225, Home: 426-9233.

GENERAL PRACTITIONERS: Have you had your fill of the "Rat Race"? Are you tired of filling out forms such as for Medicare, Medicaid, etc.? If so, come with us. We have a campus which is going to grow to 20,000 students. We will be in a new Health Service building in 1972. We offer a competitive salary, excellent fringe benefits, and the opportunity to improve yourself. Contact: Harold J. Reese, M.D., Director, Student Health Service, Central Michigan University, Mt. Pleasant, Michigan 48858. Phone (517) 774-3058.

NEW EXPANDING OPPORTUNITIES for family physicians and physicians specializing in pediatrics, internal medicine, urology, anesthesiology; in medically-awakening community. Contemporary, automated, 105-bed, new hospital to be completed in the fall of 1970. Present hospital to be converted into long-term unit. Patient service area 50,000 people. Medical staff leading and supporting recruitment efforts. Excellent community location, forty miles equidistant to Milwaukee or Madison. Complete educational, cultural and recreational facilities. A new medical — dental building and a 130-bed skilled care nursing home being constructed adjacent to the new hospital ready for occupancy January 1971. Immediate satisfaction in practice, income and family living. Special assistance if needed. Write or call Paul R. Glunz, M.D., Watertown Memorial Hospital, 1301 E. Main Street, Watertown, Wisconsin 53094; Telephone (414) 261-4210 for more information.

VACATION ON FLORIDA'S GOLD COAST: 2 bedroom T-bird villa in Coral Springs. Quiet and private. 18 hole golf course, tennis, swimming pool on premises. Available year-round on monthly or weekly rental basis. Rest and recuperate that weary mind and body. Contact Dr. J. Heidenreich, Marshall, Michigan (616) 781-7997.

Pedro Meza, M.D.
Port Huron

Pedro Meza, M.D., Port Huron physician for the past nine years, died unexpectedly June 14 at the age of 46.

Doctor Meza was a graduate of the University of Nuevo Leon Medical School, Monterrey, Mexico, and had been affiliated with the Lafayette Clinic for Children in Detroit.

He was a fellow of the American Psychiatric Association and the American Orthopsychiatric Association. He was affiliated with Port Huron and Mercy Hospitals in Port Huron.

Roy E. Newman, M.D.
Romeo

Roy Edward Newman, M.D., Romeo, former director of radiology at Alpena Hospital, died June 26 at the age of 46.

Doctor Newman was a graduate of the Wayne State University School of Medicine and was a member of the American College of Radiology.

Edward F. Swickle, M.D.
Royal Oak

Edward Frank Swickle, M.D., retired general practitioner who had served the community of Clawson for 26 years, died June 12 at the age of 59. He resided in Royal Oak.

Doctor Swickle was affiliated with Highland Park General Hospital and McNamara Hospital in Warren. He was a member of the American Academy of General Practice and was graduated from Wayne State University School of Medicine.

James H. Tuesink, M.D.
Cedar Springs

James Harvey Tuesink, M.D., Cedar Springs general practitioner for 39 years, was killed in an auto accident July 1. He was 67 and had just completed his 40th year of practicing medicine.

Doctor Tuesink was a member of the staffs of Butterworth and St. Mary's Hospitals in Grand Rapids and Greenville Memorial Hospital and was graduated from Rush Medical College, Chicago. He was a member of the American Association of General Practitioners.

Economy!

Dicarbosil®
ANTACID

Your ulcer patients and others will appreciate it. Specify DICARBOSIL 144's—144 tablets in 12 rolls.

ARCH LABORATORIES
319 South Fourth Street, St. Louis, Missouri 63102

Index to Advertisers

Arch Laboratories	849
Becton, Dickinson	777, 778
Bio-Dynamics	807, 808
*Breon Laboratories	793
*Brighton Hospital	811
Brown Pharmaceuticals	832
*Burroughs-Wellcome & Co.	819
Campbell Soup Co.	773
Carlton Corp.	795
Classified Ads	848
Conal	776
Dow Chemical	785, 786, 787, 788, 814
*Geigy	813
Hynson, Westcott and Dunning, Inc.	739
*Lederle Laboratories	740, 799, 840, 841
*Lilly, Eli and Co.	750
Loma-Linda	823
MDPAC	797
*Mead Johnson Laboratories	816, 817
*Medical Protective Co.	811
Mercywood Hospital	832
MultiVest Real Estate, Inc.	847
National Drug Co.	789, 790, 825, 826
Plainwell Sanitarium	798
Poythress, Wm. P.	820
*Professional Management	843
*Professional Service Corp.	831
*Robins, A. H.	827, 837, 838
Roche Laboratories	742, 743, Cover IV
*Sandoz Pharmaceuticals	803, 804, 805, 806
*Schering Corp.	835, 836
*Searle, G.D., and Co.	774, 775
*Stratton, Ben P., Ins.	Cover II
*Stuart	828
Walker Corp. and Co.	780, 781
*Wyeth	747, 748

*These organizations will help support the 1970 MSMS Annual Scientific Session in Detroit, Sept. 23-24 with exhibits and contributions.

noted and quoted

BY HERB AUER, EXECUTIVE EDITOR

At the summer meeting of the Michigan Academy of General Practice at Boyne Highlands, Edward J. Kowalewski, president of the American Academy of General Practice, offered some ideas to help increase the doctor supply. He suggested:

— Have all medical schools reaffirm that their main goal is to educate physicians;

— Reform the admission methods used by medical schools which have become stumbling blocks to meaningful student selection;

— Make adequate use of facilities, teachers and medical schools by developing two concomitant classes running staggered;

— Let students work at their own pace and fulfill graduation requirements sooner if they can;

— Structure health care programs without the emotional and politically-motivated backdrops of the past.

The above comments are quoted from an article by Craig A. Boike in the *Saginaw News.*

* * *

A recent, random sample of rural physicians in the USA found that the majority of them and their wives had small-town backgrounds; and similarly physicians in communities of 25,000 or more generally grew up in comparably sized cities. The survey, conducted by the AMA, found that 58 per cent of the rural doctors were engaged in solo practice, 17 in group, and 25 in various combinations of group practice, partnerships, and salary arrangements. The rural physicians reported that they preferred the slower pace, closer social ties, and greater outdoor recreational opportunities. The full results were printed in *Public Health Reports,* Vol. 85, 1970.

* * *

The Anderson, South Carolina newspaper, **Independent,** ran an ad the other day asking for help:

"We wish we knew where we put that copy of whatever newspaper it was, the date of which seems to have slipped our mind. There were two advertisements in it for memory training classes, but we've forgotten the advertisers' names."

* * *

Jenkin Lloyd Jones, newspaper publisher and U.S. Chamber president, offered this message to dissidents in a recent *Look* magazine article:

"The rebels in our midst keep asking us to understand them. But I think it is time they did some understanding of their own. They should try to understand why the much maligned American system has produced the healthiest, richest, most charitable and — in most ways — the freest society on the face of the earth. If these strident, dissident groups would pay attention to why our system works and why the systems they espouse have invariably failed, they could perform a much more useful and beneficial service for all of mankind."

Mr. Jones was one of the featured speakers at the MSMS Centennial Session several years ago.

* * *

How's this for an appropriate name?

The assistant editor of the "Journal of the National Athletic Trainers Association" is Mr. Stretch. That's right. Clyde Stretch, of MSU, is the assistant editor for the fine journal which occasionally tells athletes how to stretch and how not to.

* * *

Occasionally we like to quote from *A Century of Service in Medicine,* written about MSMS by William J. Stapleton, Jr., M.D., Detroit, our MSMS historian.

He reports that during 1944-1945, "The Michigan Foundation for Medical and Health Education was incorporated under the sponsorship of the MSMS. The purposes of the Foundation were 'to acquire, provide, use, develop, endow, and finance methods, means, and facilities for postgraduate education in medicine, for lay health education, and for research fellowships and scholarships, all in such a manner as the Trustees shall determine.' This replaces the MSMS Foundation for Post-graduate Medical Education, created in 1942."

Copies of this MSMS history are available for $2.00 from MSMS, P.O. Box 152, East Lansing, Michigan 48823.

* * *

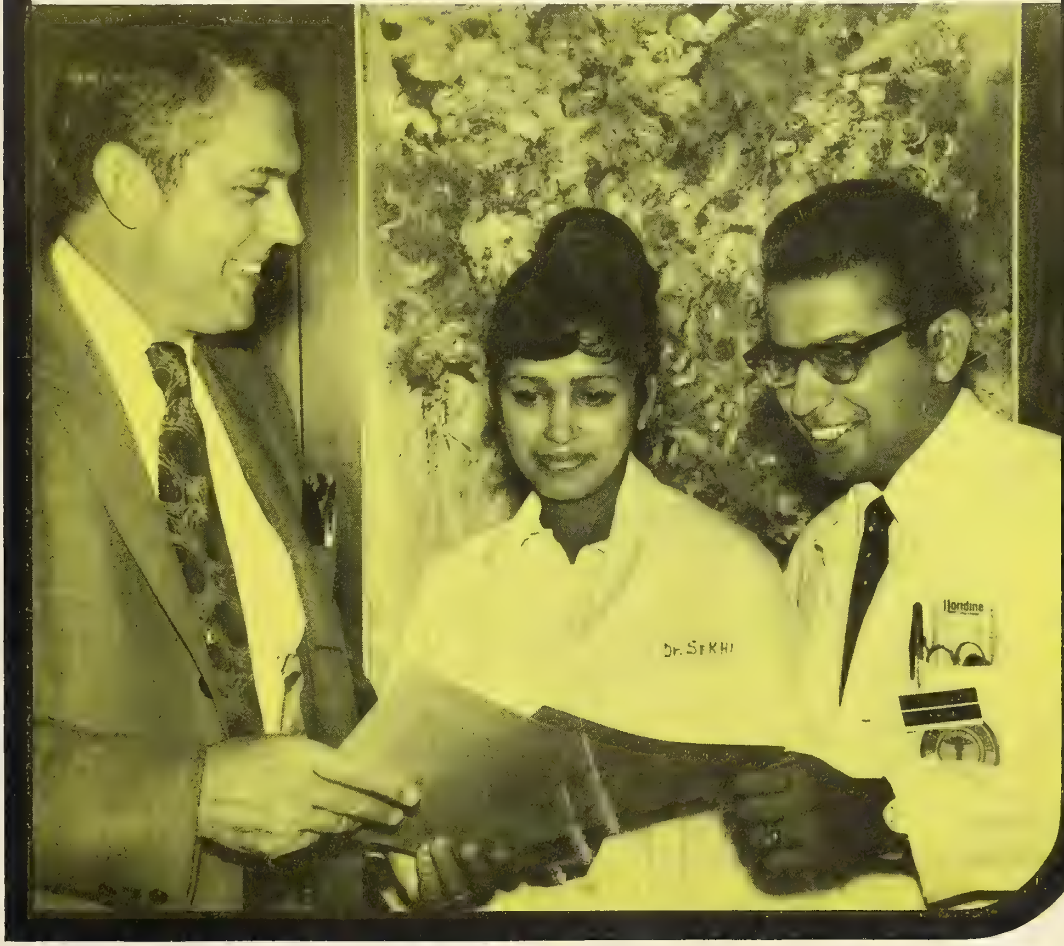
You may have heard reports before that women dispense 85 per cent of all household income. Now, the **Marketing and Communications** magazine for July, 1970, adds some other dimensions: "The power of women as consumers is formidable. They also have in their name 65 per cent of all the nation's savings accounts, 74 per cent of titles to suburban homes, and 65 per cent of the nation's private wealth. About 40 per cent of all millionaires are women."

michigan medicine

FEATURES IN THIS ISSUE	
	Mercury, Fish and Human Health
	Rock Festivals and the Medical Profession
	New MSMS President Discusses Medical Socio-Economics

U. C. SAN FRANCISCO
MEDICAL CENTER LIBRARY
NOV 3 1970

The 999th and 1,000th physicians to be placed in practice by the Michigan Health Council receive certificates on completion of residency training under Tommy N. Evans, M.D., Detroit, left. The new Michigan physicians are husband and wife team, Rama, center, and N. C. Sekharan. For details, see page 914.



Michigan State Medical Society
October 1970, Volume 69, Number 19

in cardiac edema

Dyazide®

Trademark

Each capsule contains 50 mg. of Dyrenium® (brand of triamterene) and 25 mg. of hydrochlorothiazide.

gets the water out

spares the potassium

Before prescribing, see complete prescribing information in SK&F literature or *PDR*.

Indications: Edema associated with congestive heart failure, cirrhosis of the liver, the nephrotic syndrome, late pregnancy; also steroid-induced and idiopathic edema, and edema resistant to other diuretic therapy. 'Dyazide' is also indicated in the treatment of mild to moderate hypertension.

Contraindications: Pre-existing elevated serum potassium. Hypersensitivity to either component. Continued use in progressive renal or hepatic dysfunction or developing hyperkalemia.

Warnings: **Do not use dietary potassium supplements or potassium salts unless hypokalemia develops or dietary potassium intake is markedly impaired.** Enteric-coated potassium salts may cause small bowel stenosis with or without ulceration. Hyperkalemia (>5.4 mEq/L) has been reported in 4% of patients under 60 years, in 12% of patients over 60 years, and in less than 8% of patients overall. Rarely, cases have been associated with cardiac irregularities. Accordingly, **check serum potassium during therapy, particularly in patients with suspected or confirmed renal insufficiency (e.g., certain elderly or diabetics). If hyperkalemia develops, substitute a thiazide alone. If spironolactone is used concomitantly with 'Dyazide', check serum potassium frequently**—they can both cause potassium retention and sometimes hyperkalemia. Two deaths have been reported in patients on such combined therapy (in one, recommended dosage was exceeded; in the other, serum electrolytes were not properly monitored). Observe regularly for possible blood dyscrasias, liver damage or other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving Dyrenium (triamterene, SK&F). Rarely, leukopenia, thrombocytopenia, agranulocytosis, and aplastic anemia have been reported with the thiazides. Watch for signs of impending coma in acutely ill cirrhotics. Thiazides are reported to cross the placental barrier and appear in breast milk. This may result in fetal or neonatal hyperbilirubinemia, thrombocytopenia, altered carbohydrate metabolism and possibly other adverse reactions that have occurred in the adult. When used during pregnancy or in women who might bear children, weigh potential benefits against possible hazards to fetus.

Precautions: Do periodic serum electrolyte and BUN determinations. Do periodic hematologic studies in cirrhotics with splenomegaly. Antihypertensive effects may be enhanced in postsympathectomy patients. The following may occur: hyperuricemia and gout, reversible nitrogen retention, decreasing alkali reserve with possible metabolic acidosis, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), digitalis intoxication (in hypokalemia). Use cautiously in surgical patients. Concomitant use with antihypertensive agents may result in an additive hypotensive effect.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis; rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting (may indicate electrolyte imbalance), diarrhea, constipation, other gastrointestinal disturbances. Rarely, necrotizing vasculitis, paresthesias, icterus, pancreatitis, and xanthopsia have occurred with thiazides alone.

Supplied: Bottles of 100 capsules.

SK
&F

Smith Kline & French Laboratories

Breaking News: Deadline Sept. 3
September 1970, Volume 69, Number 18
Michigan State Medical Society

U. C. SAN FRANCISCO
MEDICAL CENTER LIBRARY
OCT 1 2 1970

michigan medicine

MSMS House of Delegates Reference Committees Ready for 1970 Annual Session Action

During the 1970 meetings of the MSMS House of Delegates Sept. 20-22 in Detroit, 11 House of Delegates reference committees will meet to consider resolutions introduced and to recommend courses of action for the House.

The following are the chairmen and members of each of the reference committees:

Constitution and Bylaws—J. M. Kennary, Jr., M.D., Wayne, chairman; L. G. Bateman, M.D., Genesee; S. M. Gould, Jr., M.D., Washtenaw; G. T. Kelleher, M.D., Calhoun; F. H. Lindenfeld, M.D., Berrien; D. J. Millard, M.D., Van Buren, and J. J. Rick, M.D., Branch.

Credentials and Tellers Committee—B. D. Bauer, M.D., Oakland, chairman; J. W. MacKenzie, Jr., M.D., Genesee; A. Z. Ostrowski, M.D., Wayne; E. A. Rinkenberger, M.D., Macomb; N. A. Vanselow, M.D., Washtenaw.

Health Insurance and Medical Services—R. J. Barrett, M.D., Wayne, chairman; F. S. Gillett, M.D., Kent; Jack Hoogerhyde, M.D., Kent; F. A. Kennedy, M.D., Berrien; R. J. McMurray, M.D., Genesee; F. C. O'Dell, Jr., M.D., Alpena-Alcona-Presque Isle; R. E. Rice, M.D., Ionia-Montcalm; R. J. Toteff, M.D., Saginaw; J. A. Witter, M.D., Wayne.

Miscellaneous Business—A. L. Brown, M.D., Oakland, chairman; C. E. Conaway, M.D., Lapeer; E. J. Igna, M.D., Wayne; David Kahn, M.D., Ingham; F. P. McQuillan, M.D., Jackson; C. L. Oppy, M.D., North Central.

Public and Professional Relations—J. D. Fryfogle, M.D., Wayne, chairman; F. E. Caumartin, M.D., Wayne; H. A. Furlong, M.D., Oakland; P. G. Goodreau, M.D., Houghton-Keweenaw-Baraga; D. E. Heilbronn, M.D., Saginaw; D. B. Hiscoe, M.D., Ingham; H. A. Scovill, M.D., Washtenaw; E. B. Sherman, M.D., Eaton; E. J. Tallant, M.D., Wayne; E. S. Woodworth, M.D., Livingston.

Reports of Council and Officers—E. E. Elder, Jr., M.D., Oakland, chairman; F. B. Bicknell, M.D., Wayne; J. I. Clark, M.D., Allegan; H. W. Harris, M.D., Ingham; K. T. McGunegle, M.D., Sanilac; C. W. Oaks, Jr., M.D., Huron; D. J. Wilhelm, M.D., St. Clair.

Resolutions—R. M. Stow, M.D., Ingham, chairman; C. W. Colwell, M.D., Genesee; C. E. Darling, M.D., Wayne; R. J. Fisher, M.D., Washtenaw; R. R. Galpin, M.D., Oakland; V. A. Marks, M.D., Midland; D. F. Sarapo, M.D., Lenawee; H. M. Smathers, M.D., Wayne.

Rules and Order of Business—C. M. Ebner, M.D., Macomb, chairman; R. H. Evans, M.D., St. Joseph; W. K. Locklin, M.D., Kalamazoo; L. E.

(Continued on Page 856)

SEPTEMBER
23

"You're responding nicely, Pebblewaite. I'm due to be treated myself—in Detroit at the 1970 MSMS Annual Session—to the best medical advice in the world."

"Med Students Get Head Start" was the headline on the fine layout of photos and copy in the **Detroit News** after the MSMS-called news conference about the SAMA-MECO pilot project. Answering questions at the news conference to explain the MSMS-MHA placement of 11 medical students in community hospitals for the summer were two SAMA members and two physicians. Shown left to right in the news conference at the Wayne County Medical Society building were Harold C. Mack, MD, director of Hutzel Hospital, Detroit; Randall Riggs and Richard Valentine, sophomore medical students at Wayne State University, and Walter F. Kujawski, MD, coordinator for the training project at Cottage Hospital. (See September journal for feature article issue of **Michigan Medicine** for details.)

Michigan Chapter, American College of Emergency Physicians, Annual Meeting Sept. 24, Detroit

The Michigan Chapter of the American College of Emergency Physicians will hold its 1970 annual meeting program concurrently with the MSMS Annual Scientific Session. The Michigan Chapter of the ACEP will meet Sept. 24, at Howard Johnsons Motor Lodge, Detroit.

A Membership Luncheon will begin at noon in the Ambassador Room with Gaius D. Clark, M.D., Michigan Chapter president, presiding. An open panel discussion entitled "Emergency Treatment of the Comatose Patient Including Dangers Involved in Over- and Under-treatment," will follow at 1 p.m.

Panel members include Jere M. Bauer, M.D., associate professor of internal medicine at the University of Michigan; Raymond B. Bauer, M.D., professor in the Department of Neurology at Wayne State University; Joseph L. Ponka, M.D., senior associate surgeon at Henry Ford Hospital; John G. Wiegenstein, M.D., Lansing, chairman of the board, ACEP.

Interested physicians should register for the luncheon with the ACEP Headquarters at 120 West Saginaw Street, East Lansing, Michigan 48823.

More Medical Students Than Ever Entering Michigan Schools This Fall

Forty-four more freshman students will be entering Michigan's three medical schools this fall than were enrolled for fall, 1969.

Wayne State University has increased its freshman enrollment from 130 in both 1968 and 1969 to 165 students. The University of Michigan will enter 224 freshman medical students, compared to 205 in 1968 and 225 in 1969. Michigan State University has again increased its enrollment from 26 freshman medical students in 1968 and 30 freshmen in 1969 to 40 freshmen in 1970.

County Medical Societies to Participate In 1970 Community Health Week Oct. 18-24

Early reports from several county medical societies indicate that projects in health career recruitment and drug education will be featured during the 1970 Community Health Week, October 18-24.

Once again, the AMA-sponsored Community Health Week is being carried out by the component societies, with state-wide assistance given by MSMS, Michigan Health Council and the Michigan Association of the Professions as in the past.

There will be considerable focus this fall on health careers. The MSMS House of Delegates in September will consider several resolutions and reports dealing with the need for more physicians and allied health personnel.

Michigan TB, Thoracic Organizations To Hold Annual Meeting Oct. 21-22

The Michigan Tuberculosis and Respiratory Disease Association, the Michigan Thoracic Society and the Michigan Conference of Tuberculosis Association Workers will hold a joint annual meeting Oct. 21-22 at the Northland Inn, Southfield.

Air conservation, Michigan's ninth grade tuberculin skin testing program and the critical health problems of Michigan's youth will be among the topics.

Speakers designated so far for the meeting include Robert Anderson, Ph.D., assistant director for the Michigan State University Institute for Community Development; Bernard Bloomfield, Michigan Department of Public Health; and representatives of the National Tuberculosis and Respiratory Disease Association, the auto industry and a citizens' group for cleaner air.

Wilbur Steininger, M.D., medical director for the North Carolina Sanatorium, will discuss progress in the management of tuberculosis and Maurice S. Reizen, M.D., director of the Michigan Department of Public Health, will also speak.

Stapleton Reading Room at Shiffman Medical Library To Be Dedicated Sept. 24 in Detroit

Doctor Stapleton

The William J. Stapleton Reading Room in the new Wayne State University Shiffman Medical Library will be formally dedicated at noon Thursday, Sept. 24, during the 1970 MSMS Annual Session.

A special guest at the ceremonies will be William J. Stapleton, Jr., M.D., for whom the room is named. Now in his 90s, Doctor Stapleton is former associate dean of the WSU School of Medicine and past president of the Wayne County Medical Society.

The dedication for the reading room, to be reserved for WSU School of Medicine alumni, has been arranged by the WCMS Library Committee, led by Chairman Don W. McLean, M.D. Buses will transport interested MSMS members from the Annual Session at the Sheraton-Cadillac Hotel to the library at the Detroit Medical Center and then to a 1 p.m. subscription luncheon at the WCMS headquarters.

Contributions from the WCMS members and the Wayne County Health Foundation have made the Stapleton Room possible and provided for furnishings. They include paneled walls, oak parquet floor, hand-woven oriental rugs, a portrait and bas relief of Doctor Stapleton, bronze plaque, pictures and a dedication plaque.

County Societies in the Second MSMS Councilor District and Michigan Blue Shield have been notified of the formation of the new Regional Medical Advisory Committee, which also includes, from left, Harold E. Crow, M.D., Lansing; George D. Stilwill, M.D., Lansing, and Duane M. Allen, M.D., Hanover, who was elected vice chairman.

The chairman for the new Regional Medical Advisory Committee for the Second MSMS Councilor District, Benjamin J. Stone, M.D., East Lansing, right, confers with committee member George W. Bennett, M.D., Elsie.

Regional Medical Advisory Committee Organized In Second MSMS Councilor District

The Regional Medical Advisory Committee for the Second MSMS Councilor District is awaiting an opportunity to begin work following its organizational meeting recently at MSMS headquarters.

One of several being formed around the state in each of the MSMS councilor districts, the committee will serve as an intermediate review board between the county and state medical society peer review committees in disputes involving health insurance carriers and physicians.

In response to recent controversy and allegations of abuse and/or over-use of Medicare and Medicaid, MSMS issued a statement to re-emphasize that peer review has long been in operation by medical societies.

The new Regional Advisory Committees have been formed to provide a third step in the mechanism of review, and to be available when carrier-physician disputes cannot be settled with the physician or the county medical society.

The new committee for the Second Councilor District elected Benjamin J. Stone, M.D., East Lansing, as its chairman and Duane M. Allen, M.D., Hanover, as vice chairman.

Others on the committee are George W. Bennett, M.D., Elsie; Albert H. Meinke, Jr., M.D., Eaton Rapids; Robert G. Combs, M.D., Lansing; Harold E. Crow, M.D., Lansing; James F. Scallin, M.D., Lansing; Joseph L. Sheets, M.D., Lansing; George D. Stilwill, M.D., Lansing, and Edward R. Weddon, M.D., Stockbridge. Most are alternate delegates to the 1970 MSMS House of Delegates.

The Second District committee decided at its organizational meeting that it would not turn down cases, but would either make a decision on each case referred to it, or pass the case on to the MSMS Committee on Utilization Review and Health Insurance Problems.

They learned that word calling them into action on a case might come from the physician or insurance carrier involved or from the county society peer review committee which had first been asked to resolve the dispute.

They also agreed to notify the county societies in their district and Michigan Blue Shield of the committee's existence and its willingness to help in disputed cases.

Read It First In **Michigan Medicine**

Reports of actions taken by the 1970 MSMS House of Delegates in its Annual Session and photo highlights of the MSMS Scientific Sessions will appear in the October News Extra and November issues of *Michigan Medicine.*

Reorganization of Blue Shield Corporation On MSMS Annual Session Agenda

By Michigan Blue Shield

Michigan Blue Shield told State Insurance Commissioner Russell E. Van Hooser on Aug. 25 that it is proposing corporate reorganization to increase consumer and public representation in membership of the corporation and on its Board of Directors.

The reorganization would reduce physician membership in Blue Shield's corporation from 90 percent to 47.2 percent, and include hospital and pharmaceutical representatives. The balance would be made up of 41.7 percent consumer representation, divided among representatives of labor and industry and subscriber groups, and 11.1 percent public representation.

The same proportions of representation would hold for the new Blue Shield Board of Directors, which presently has a 60 percent physician membership.

Corporate Meeting Sept. 22

To become effective, details of the proposal must be approved by the present corporate body, which meets Sept. 22 in Detroit in connection with the annual meeting of the House of Delegates of the Michigan State Medical Society. An election of officers will also take place at that time.

"The restructuring proposed is the result of many months of extensive study," Robert H. Hamburg, M.D., chairman of the present board, and John C. McCabe, president of Blue Shield, said in a joint statement.

"The need for change was recognized some time ago and has been increasingly strongly urged by many in the medical profession, by consumers, labor and government.

"Blue Shield began internal consideration of alternative methods of reorganization last year, and the board's executive committee was formally assigned to the analysis in February. The committee unanimously recommended this plan Aug. 12, and the Board of Directors accepted the recommendation by formal resolution at a special meeting Aug. 19.

"It is our general feeling that the plan maintains our traditional close association with the providers of care yet recognizes the increasing importance of the voices of the consumers and the public in the rapidly changing climate of medical economics. We believe this new organization, if accepted, will enable Blue Shield to meet the changes firmly with actions representative of all of the people."

Doctor Hamburg and Mr. McCabe said that Blue Shield has long since expanded beyond its depression-born beginnings in 1939, when concerned physicians created it largely to prepay health care costs for primarily low income persons.

From that emergency financing, Michigan Blue Shield has grown into one of the largest such plans in the nation, serving more than 5,000,000 subscribers in its regular business and more than 6,000,000 persons including those assisted under government programs.

"Understandably, one result of the changing economy and our changing health care forms of protection has been an insistence on broadened representation of the public and consumer," the statement asserted.

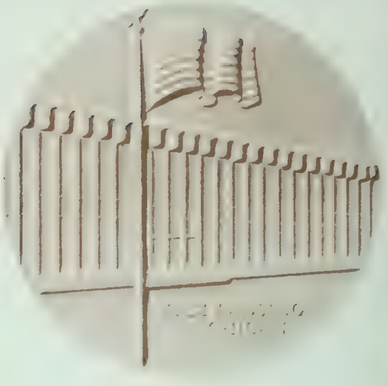
The present Blue Shield corporate body is made up of all persons who are members of the House of Delegates, about 175 persons, plus directors of Blue Shield and such other persons as the directors may elect, providing that not more than 10 percent of the membership shall be made up of "such other persons not practicing a healing art."

Smaller Corporate Body Proposed

The new corporate body would consist of 108 persons. Of these, under the category of providers, 36 would be doctors of medicine, six would be doctors of osteopathy, six would represent hospitals and three would represent pharmacists, for a total of 51. Under the category of consumers, nine would be representatives of labor, and 36 would be representatives of industry and substantial purchasing groups, for a total of 45. Under the category of public representatives, six would be nominated by the State Insurance Commissioner, none of whom could hold elective office or be affiliated with the insurance industry, and six other members of the public, who could be public officials but who could not be affiliated with the industry, for a total of 12.

The present Board of Directors consists of 35 persons, 21 of whom must be physicians and 14 of whom are public members.

The new Board would be composed of 36 persons, made up of 17 providers of care to include 12 doctors of medicine, two doctors of osteopathy, two hospital representatives and two pharmaceutical representatives; 15 consumer representatives, including three from labor and 12 from industry and substantial purchasing groups; and four public representatives, two to come from each of the categories named.



MSMS House of Delegates to Hear MSMS Management Study Report

The results of the recent management study of MSMS and the reorganization of the staff will be explained by The Council to the House of Delegates in Detroit.

Delegates have received a detailed written report which has been discussed at the various Councilor District Conferences.

Last year, The Council recommended and the House approved a management study by the Alexander Grant organization to review the MSMS staff and to receive any recommendations for improving, streamlining and increasing the efficiency of the MSMS management.

The management study was under the responsibility of the MSMS Task Force (Speaker James B. Blodgett, M.D., Acting Chairman.) The Alexander Grant report was presented to the Task Force in May and to the full Council on May 27. The Council approved the study recommendations.

Coincidental with the adoption of the study recommendations, Hugh W. Brenneman announced his intention on May 27 to run for political office and Warren F. Tryloff was appointed director of MSMS.

Recommendations of the Management Study have led to a new staff organization. The director is at the head of a businesslike management staff, which reports directly to him. The rest of the operation is under three managers; i.e., Government Relations Department Manager, Communications and Professional Information Department Manager, and Operations and Economics Department Manager. The staff was organized this summer along traditional vertical report lines which provide for a clearer understanding of responsibilities, holding each manager responsible and accountable for the objectives and activities within each department, according to Ross V. Taylor, M.D., Council chairman.

Staff Reorganization

The reorganization of the staff was completed in late June. It resulted in the elimination of one clerical position. As of this writing, the managers of the departments are: Government Relations—Stewart Kerr (Acting Manager); Communications and Professional Information—Herbert Auer; Operations and Economics—Richard Campau, who returns to MSMS.

The Council is actively seeking an outstanding candidate for the manager of the Government Relations Department. At this writing, several candidates are being considered, but in the interim the department has the expert advice and guidance of Mr. Kerr, MSMS legal counsel, during these months of low legislative activity. This allows The Council adequate time to obtain the best possible department manager.

Because of the restructuring of the staff, it was possible to redefine the job descriptions of the employees and to turn over certain responsibilities to other members of the staff. Mr. Ralph Wills accepted early retirement as of September 1 and his former duties will be assumed by other members of the staff.

Doctor Taylor reports, "that while the management of MSMS has been streamlined and the potential for efficiency highly increased, a great deal of work needs to be done. Mr. Tryloff is faced with the responsibility of incorporating and implementing the detailed recommendations of the

---

(Concluded from Page 851)

Simoni, M.D., Genesee; H. C. Tellman, M.D., Muskegon; F. B. Walker, II, M.D., Wayne; W. J. Yott, M.D., Wayne.

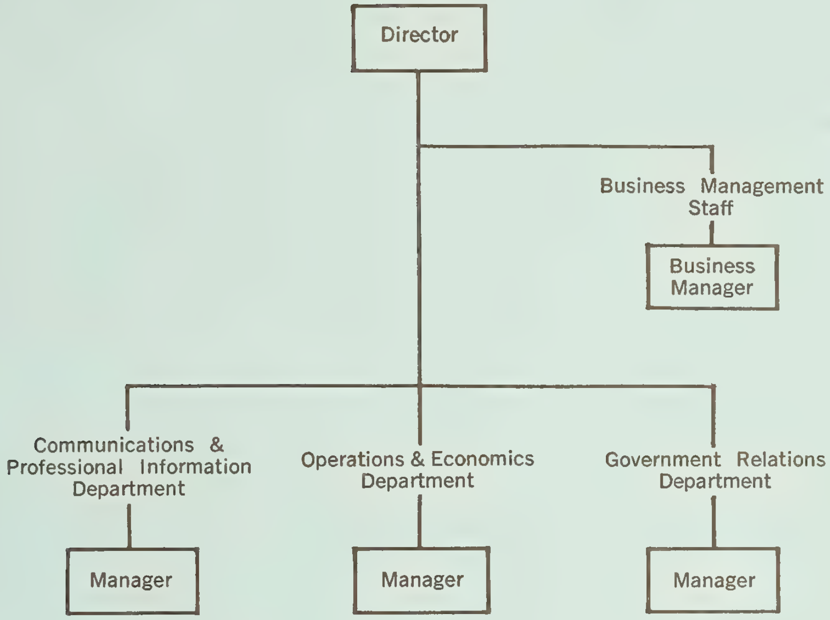
Special Memberships—D. D. Finlayson, M.D., Chippewa-Mackinac, chairman; B. G. Keizer, M. D., Luce; Kornelius Van Goor, M.D., Kent.

State and Federal Legislation—N. L. Avery, Jr., M.D., Kent, chairman; R. J. Bower, M.D., Kalamazoo; Benjamin Jeffries, M.D., Wayne; P. T. Lahti, M.D., Oakland; J. A. McLaughlin, M.D., Oakland; William Rottschaefer, M.D., Ottawa; L. R. Zako, M.D., Wayne.

Ways and Means—J. M. Moses, M.D., Wayne, chairman; R. C. Deming, M.D., Jackson; A. F. Dundon, M.D., Grand Traverse-Leelanau-Benzie; A. J. Neerken, M.D., Kalamazoo; H. L. Nigg, M.D., Tuscola.

Parliamentarian—Mr. A. Stewart Kerr

Proposed Interim Organization
Michigan State Medical Society Staff


Director
Business Management Staff
Business Manager
Communications & Professional Information Department
Operations & Economics Department
Government Relations Department
Manager
Manager
Manager

management study in relation to personnel policies, salary administration, etc., etc.

"The Council will tell the House of Delegates, that the management study was most worthwhile and fits in, in time and importance, with both the short-term and long-range planning that is now going on within The Council structure."

New Committee

During the past year, The Council created a Committee on Planning and Priorities which has the establishment of long-range MSMS objectives as one of its major goals. This Committee agreed to 1) review current purposes of MSMS, 2) study the problems facing medicine and MSMS members, 3) review efforts to solve these problems, 4) determine the effectiveness of these efforts, and 5) decide if more needs to be done.

Doctor Taylor explains, "the work of this Committee and of The Council will lead to a re-evaluation of all the activities of MSMS, and probably the elimination of some of the traditional activities to the Society, to be replaced by problem-solving efforts on more contemporary issues. This will have an effect on the financial future of MSMS, the attractiveness of organized medicine to new physicians graduating in the future, and, in fact, a vital effect on the whole future of the state medical association in the next decade."

The supply of printed materials to help the doctor better understand medical and social problems and to assist him in his dealings with patients is almost inexhaustible. Examples are the three brochures listed here, which are available by checking this coupon, detaching it and mailing it to MSMS, 120 W. Saginaw St., East Lansing 48823. (Your mailing address is already on the back.)

________Pamphlet prepared by the Governor's Office of Drug Abuse informing the reader of types of drugs abused; the drug abuser's language; medical uses, symptoms and dependence potentials of various drugs and answers to often-asked questions.

________Pamphlet prepared by the Governor's Office of Drug Abuse on how to organize a community action plan, how to set up treatment and rehabilitation programs and where to go for information and educational help in each county.

________Pamphlets containing the "Declaration of Helsinki," listing recommendations guiding doctors in clinical research, adopted by the World Medical Association in 1964.

AAGP to Recognize MSMS Annual Session for Credits

The American Academy of General Practice has approved the MSMS Annual Session and its four all-day postgraduate courses for elective credit. The requests were submitted to AAGP by Cecelia F. Hissong, M.D., Dearborn, from the Michigan Academy of General Practice.

GPs attending the MSMS Annual Session on September 24 from 8 to 5 will be able to receive 10 hours of elective credit.

The all-day postgraduate course Wednesday, September 23 on "Hypertension" has been accepted for 5 elective hours.

The all-day course Wednesday, September 23 on "Clinical Pharmacology and Therapeutics" has been accepted for 6 elective hours.

The all-day course Thursday, September 24 on "Allergy for Non-Allergists" has been accepted for 6 elective hours.

The all-day course Thursday, September 24 on "Shock, Blood, Fluids and Electrolytes" has been accepted for 6 elective hours.

MSMS to Co-sponsor Public Forum on Emphysema Sept. 23 at Ford Auditorium, Detroit

A public forum on emphysema is planned at 8 p.m. Sept. 23 in the Ford Auditorium, Detroit, by the Michigan State Medical Society, Michigan Tuberculosis and Respiratory Disease Association, Wayne County Medical Society, Tuberculosis and Health Society of Wayne County and the *Detroit News*.

Similar in format to the highly-successful public forums held last year on arthritis, diabetes, heart disease and health careers, the forum will feature a panel discussion by experts on various aspects of emphysema.

Moderator and chairman will be E. Osborne Coates, M.D., Detroit, physician in charge of the Pulmonary Section at Henry Ford Hospital. On the panel will be Benjamin Lewis, M.D., Wayne State University School of Medicine; Tom M. Johnson, M.D., associate professor, Michigan State University College of Human Medicine, and Gerald L. Baum, M.D., chief, Pulmonary Section B, Veterans Administration Hospital, Cleveland. Doctor Baum will discuss "Rehabilitation of the Chronic Obstructive Diseased Patient."

Tickets are available from the Tuberculosis and Health Society of Wayne County, 153 E. Elizabeth, Detroit, Mich. 48201.

michigan medicine

MICHIGAN STATE MEDICAL SOCIETY

Published semi-monthly, Trimonthly in December; 25 issues, by the Michigan State Medical Society as its official journal. Second class postage paid at East Lansing, Mich. and at additional mailing offices. Yearly subscription rate, $9.00. Printed in USA. All communications should be addressed to the Publications Committee, Michigan State Medical Society, 120 West Saginaw Street, East Lansing, Michigan 48823. © 1970 Michigan State Medical Society. Phone: Area Code 517, 337-1351.

Second Class Postage Paid at East Lansing, Mich. and at additional mailing offices.

UNIVERSITY OF CAL
LIBRARY SCH OF MED
THIRD & PARNASSUS AVE
SAN FRANCISCO CAL 94122

Attention Librarians: This publication is a regular issue of MICHIGAN MEDICINE and should be saved for binding later with the larger scientific issues of the journal.

Breaking News: Deadline September 29
October 1970, Volume 69, Number 19
Michigan State Medical Society

michigan medicine

Doctor Mason Recommends Consumer Committee, Past Officers Committee, "Teen Week"

In his exaugural address before the 1970 MSMS House of Delegates Sept. 20 in Detroit, Immediate Past President Robert J. Mason, M.D., called for the formation of a medical society advisory committee of consumers or local opinion makers and medical-society sponsorship of a statewide "Youth Week in Health."

Doctor Mason, of Birmingham, also recommended establishment of a medical society advisory committee of past officers. He addressed the House of Delegates in the opening session of their three-day annual meeting at the Sheraton-Cadillac Hotel, Detroit.

Doctor Mason's consumers advisory committee, he said, could advise MSMS on the impact of medical programming on the total community. "The AMA has such a new advisory council and early reports are encouraging," he reported.

He suggested the "Teen Week" or "Youth Week in Health" to bring together outstanding high school juniors and seniors for a conference geared to the adolescence and youth concerns they are encountering.

"Virtually every youth issue today—drugs, smoking, family-life education—is health-related and the medical profession can offer answers and advice," he pointed out.

Southwest Michigan Clinic Day Oct. 29

Four out-of-state physicians will lead the faculty for the annual Southwestern Michigan Clinic Day planned Oct. 29 at the Battle Creek Country Club. Registration will begin at 9 a.m.

Among the faculty of seven will be Victor A. McCusick, M.D., Department of Internal Medicine, Johns Hopkins University; Lester Persky, M.D., Department of Urology, Western Reserve University; Watts R.

The sale of the AMA reference book, **Today's Health Guide,** will be promoted this coming year by the MSMS Committee on Public Relations. Examining copies are, left to right, John A. Doherty, executive secretary of the Michigan Health Council; Donald DeWitt, M.D., and Joel E. Hamburger, M.D., both members of the PR committee, and Herbert A. Auer, manager of the MSMS Communications Department.

Webb, M.D., Syracuse University and Albert A. Kattus, M.D., Internal Medicine Department, University of California.

Doctor Webb, who is professor and chairman of the Department of Surgery at the Upstate Medical Center of the State University of New York, will deliver the annual Russell L. Mustard Memorial Lecture. His topic will be "Coronary Artery Disease."

MSU D.O. School Officially Established; Myron S. Magen, D.O., First Dean

The first doctor of osteopathy degrees are expected to be granted in 1973 from Michigan State University's new College of Osteopathic Medicine, which was offically established in East Lansing Sept. 17.

Myron S. Magen, D.O., is the first dean of the MSU osteopathic school, appointed after serving for the last three years as dean of the privately-chartered Michigan College of Osteopathic Medicine (MCOM) at Pontiac.

Doctor Magen will serve part-time until January when he will become full-time. The MSU trustees also granted temporary appointments to all of the Pontiac school's faculty and other employes.

The osteopathic program at Pontiac is to be assimilated within the university at East Lansing over the next two years and MSU representatives will be consulting with Pontiac community leaders about future use of the 164-acre site of the MCOM where two buildings have been constructed.

International Experts in Drug Abuse To Address U-M Conference Nov. 9-13

It is the aim of planners of the International Drug Abuse Symposium scheduled Nov. 9-13 at the University of Michigan to "make this an outstanding conference, bringing together international and national figures who are contributing to the advance of knowledge bearing on this particularly important medical-social-legal problem."

So says Harry A. Towsley, M.D., director of postgraduate Medical Education at the U-M Medical Center, where the conference, aimed at the physician, will be held.

Among the speakers will be Henry W. Elliott, M.D., of the University of California; Leo Hollister, M.D., Veterans' Administration Hospital, Palo Alto; Joseph Seifter, M.D., New York Medical College; Jerome Jaffe, M.D., University of Chicago; Abraham Kaplan, Ph.D., professor of philosophy and Maurice Seevers, M.D., professor of pharmacology, both of the U-M faculty.

Family Practice Day Scheduled Oct. 11 in Lansing

Senior medical students at Wayne State University and the University of Michigan, junior medical students at Michigan State University and interns in hospitals across Michigan are invited to a Family Practice Day Sunday, Oct. 11, at E. W. Sparrow Hospital, Lansing.

Lansing is the third city in Michigan to have a center officially sanctioned by the new family practice specialty.

During the morning session of the Family Practice Day, directors of the three Michigan centers—Robert Bowsher, M.D., of Midland; Roy Gerard, M.D., of Saginaw, and H. E. Crow, M.D., of Lansing—will participate in a panel discussion on their family practice programs.

Fall Series of PG Courses Set in Michigan Communities by MSMS

Michigan physicians will have the opportunity to expand their knowledge in a variety of medical areas by attending one of the series of fall postgraduate courses planned by MSMS in communities around the state.

As in previous series of the biannual PG courses sponsored by MSMS, visiting faculty members from the state's medical schools will consult with local doctors on interesting and difficult cases, leading a clinical meeting during the afternoon, and lecturing after a dinner meeting.

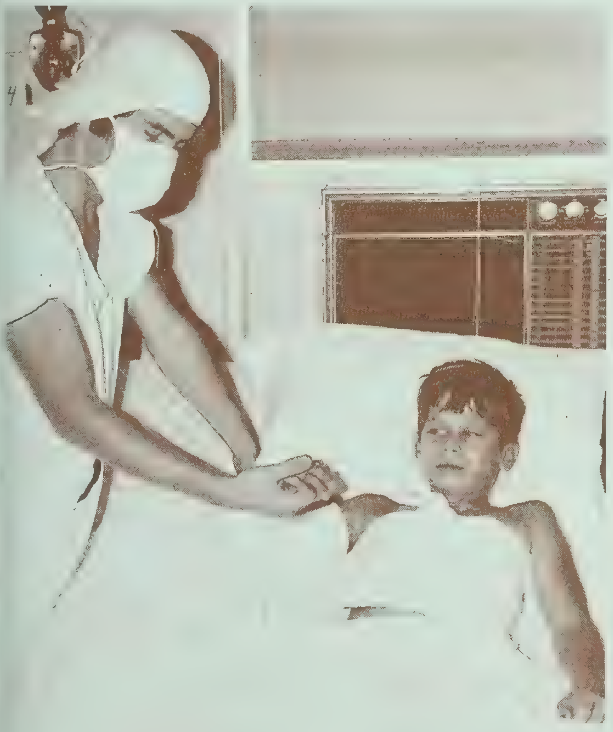
The schedule follows of dates and places where the courses will be held:

Oct. 2 — Holland
Oct. 6 — Battle Creek
Oct. 6 — Traverse City
Oct. 14 — Grayling
Oct. 19 — Houghton
Oct. 19 — Muskegon
Oct. 19 — Sault Ste. Marie
Oct. 20 — Escanaba
Oct. 20 — Ironwood
Oct. 21 — Iron Mountain
Oct. 21 — Menominee
Oct. 22 — Marquette
Oct. 28 — St. Joseph
Oct. 29 — Alpena
Nov. 3 — Port Huron
Nov. 4 — Howell
Nov. 12 — Petoskey
Nov. 13 — Midland

Gov. Milliken Names Four Physicians To State Mental Health Council

Four of the eight new members of the State Advisory Council on Mental Health Services are Michigan physicians. They were named recently by Governor Milliken to the Council, to serve four-year terms.

The physicians are Benjamin Jeffries, M.D., Harper Woods; Stuart M. Finch, M.D., Ann Arbor; George D. Maniaci, M.D., Gladstone, and Edward H. Rodda, M.D., Bay City. All are former members of the Mental Health Advisory Council.



A nurse's aide, Steve Rowe, examines the hand of a youngster in the new "model" Burn Unit at University Hospital, Ann Arbor. The unit, which opened Aug. 30, is organized into three separate areas for emergent, acute and rehabilitive care of the burn patient. Under a five-year grant from the United States Public Health Service, the burn unit has also included such renovations as an operating room, ambulatory patient room, hemodialysis area, hydrotherapy room and treatment area. Irving Feller, M.D., is director of the Hospital Burn Center.

WA-MSMS Has Successful Programs, Mrs. Maxim Reports

Major concerns of the Woman's Auxiliary to the Michigan State Medical Society during the past year have been mental health, better emergency services, the AMA's Education and Research Foundation, and membership.

Auxiliary activity on those subjects was summarized in a written report prepared for the MSMS House of Delegates' annual meeting Sept. 20-22, by Mrs. Edward S. Maxim, 1969-70 WA-MSMS president.

Nearly every county auxiliary had a program on drug abuse, she reported. Statewide, eleven were instrumental in initiating community programs about drug abuse, a mental health workbook for the use of county auxiliary chairmen was prepared, over $2,000 was spent on community mental health projects, and nine counties had members working in state mental institutions.

State Board of Education Finally Approves Sex Education Document

After a two-year public controversy, the State Board of Education gave unanimous approval late in August to a compromise plan to assist local public school superintendents and administrators attempting to offer sex education instruction.

The plan, fifth in a series of guideline proposals, leaves details of sex education programs in Michigan to local school systems, because, it says, "administrative and staff competence and parental attitudes vary widely; community readiness tends to differ between areas, and many school districts have been dealing with sex education effectively for a long time."

CAPSULES

Michigan physicians are specially invited to attend the 121st Annual Convention of the Indiana State Medical Association, scheduled Oct. 13-15 at the Athletic and Convocation Center on the University of Notre Dame campus at South Bend.

* * *

The American College of Physicians will present a postgraduate course on Interviewing, Data Gathering and Record Systems for the 1970s. The course is scheduled Oct. 12-15 at Michigan State University, sponsored by the Departments of Psychiatry, Medicine and Human Development.

* * *

Appointment of A. Martin Lerner, M.D., as chief of the department of Medicine at Hutzel Hospital, Detroit, has been announced. Doctor Lerner retains his positions as head of the sections of infectious diseases at the Wayne State University School of Medicine and consultant on infectious diseases at the VA Hospital, Allen Park, and Sinai Hospital, Detroit.

* * *

Component medical societies in Michigan and MSMS will participate in the AMA-sponsored Community Health Week, Oct. 18-24, 1970. Once again, statewide activities are being sponsored by MSMS, the Michigan Health Council and the Michigan Association of the Professions.

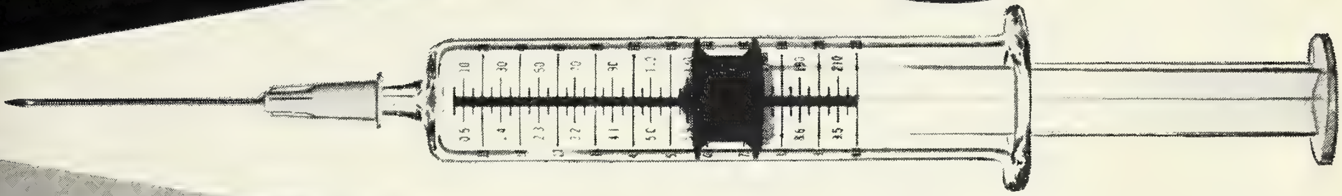
MICHIGAN MEDICINE is published Semi-Monthly, Trimonthly in December; 25 issues, by the Michigan State Medical Society, 120 W. Saginaw, East Lansing, Mich. 48823. Second class postage paid at East Lansing, Mich. and at additional mailing offices.

BSP® DISPOSABLE UNIT

HW&D BRAND OF SODIUM SULFOBROMOPHTHALEIN INJECTION, USP

(50 mg. per ml.)

BSP®



BROMSULPHALEIN® IN A STERILE, DISPOSABLE, ECONOMICAL UNIT

The Bromsulphalein test is a convenient, sensitive, reliable test of liver function.

The precalibrated syringe contained in the BSP Disposable Unit makes weight calculations unnecessary, providing proper dosage regardless of patient-weight. Each unit contains complete directions for use, precautions and contraindications.

The all-inclusive BSP Disposable Unit provides economic unit dispensing.

Complete literature available on request.

HYNSON,
WESTCOTT &
DUNNING, INC.

HW&D **Baltimore, Maryland 21201**

(BSP04)

A urinary tract infection was eliminated last week

Intestinal monilial overgrowth has appeared this week

For women who are diabetic or debilitated, oral antibiotic therapy often sets the stage for monilial overgrowth in the intestine.

When you anticipate such a problem, take action with DECLOSTATIN 300. It combines the broad-spectrum potency of demethylchlortetracycline with the antifungal effectiveness of nystatin—it helps avoid monilial take-over. Experience has shown DECLOSTATIN to be highly useful for many women patients; individual culture studies will show exactly where this usefulness may best be applied.

It doesn't let monilia begin where bacteria end.

Declostatin® 300

Demethylchlortetracycline HCl 300 mg and
Nystatin 500,000 units Capsule-Shaped Tablets Lederle

Effectiveness: Because its antibacterial component is DECLOMYCIN® Demethylchlortetracycline, DECLOSTATIN should be equally or more effective therapeutically than other tetracyclines in infections caused by tetracycline-sensitive organisms. The antifungal component, nystatin, protects against superinfection by antibiotic-resistant fungal overgrowth (particularly monilia) in the intestinal tract.

Contraindication: History of hypersensitivity to demethylchlortetracycline or nystatin.

Warning: In renal impairment, usual doses may lead to excessive accumulation and liver toxicity. Under such conditions, lower than usual doses are indicated and, if therapy is prolonged, serum level determinations may be advisable. A photodynamic reaction to natural or artificial sunlight has been observed. Small amounts of drug and short exposure may produce an exaggerated sunburn reaction which may range from erythema to severe skin manifestations. In a smaller proportion, photoallergic reactions have been reported. Patients should avoid direct exposure to sunlight and discontinue drug at the first evidence of skin discomfort. Necessary subsequent courses of treatment with tetracyclines should be carefully observed.

Precautions: Overgrowth of nonsusceptible organisms may occur. Constant observation is essential. If new infections appear, appropriate measures should be taken. In infants, increased intracranial pressure with bulging fontanels has been observed. All signs and symptoms have disappeared rapidly upon cessation of treatment.

Side Effects: Gastrointestinal system—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. Skin—maculopapular and erythematous rashes; a rare case of exfoliative dermatitis has been reported. Photosensitivity; onycholysis and discoloration of the nails (rare). Kidney—rise in BUN, apparently dose-related. Transient, reversible, nephrogenic diabetes insipidus with excessive thirst and polyuria (rare). Hypersensitivity reactions—urticaria, angioneurotic edema, anaphylaxis. Teeth—dental staining (yellow-brown) in children of mothers given this drug during the latter half of pregnancy, and in children given the drug during the neonatal period, infancy and early childhood. Enamel hypoplasia has been seen in a few children. If adverse reaction or idiosyncrasy occurs, discontinue medication and institute appropriate therapy. Demethylchlortetracycline may form a stable calcium complex in any bone-forming tissue with no serious harmful effects reported thus far in humans.

Average Adult Daily Dosage: One tablet b.i.d. Should be given 1 hour before or 2 hours after meals, since absorption is impaired by the concomitant administration of high calcium content drugs, foods and some dairy products. Treatment of streptococcal infections should continue for 10 days, even though symptoms have subsided.

Lederle LEDERLE LABORATORIES, A Division of American Cyanamid Company, Pearl River, New York 450-9

michigan medicine

SCIENTIFIC EDITOR
John W. Moses, MD

EXECUTIVE EDITOR
Herbert A. Auer

MANAGING EDITOR
Judith Marr

ASSOCIATE SCIENTIFIC EDITORS
Jason Bodzin, MD
Detroit, House Staff
Frederick J. Cady, Jr., MD
Saginaw, Surgery
Robert M. Daugherty, MD
East Lansing, Basic Science
Harold E. DePree, MD
Kalamazoo, Medicine
Dean C. Elliott, MD
Petoskey, Otolaryngology
Tommy N. Evans, MD
Detroit, Obst.-Gyn.
E. Richard Harrell, MD
Ann Arbor, Dermatology
Dorin L. Hinerman, MD
Ann Arbor, Pathology
Samuel D. Jacobson, MD
Detroit, Medicine
Benjamin Jeffries, MD
Detroit, Psychiatry
Raymond S. Kurtzman, MD
Detroit, Radiology
A. Martin Lerner, MD
Detroit, Medicine
John C. Peirce, MD
Grand Rapids, Medicine
Frank H. Power, MD
Traverse City, Surgery
J. G. Turcotte, MD
Ann Arbor, Surgery
Alexander J. Walt, MD
Detroit, Surgery
Park W. Willis, III, MD
Ann Arbor, Medicine
Richard E. Wunsch, MD
Traverse City, Medicine

PUBLICATION COMMITTEE
Brooker L. Masters, MD
Chairman
Robert M. Leitch, MD
William A. LeMire, MD
Don Marshall, MD
Don W. McLean, MD
Milton R. Weed, MD

MICHIGAN MEDICINE is the official organ of the Michigan State Medical Society, published under the direction of the Publication Committee. Published Semi-Monthly, Trimonthly in December; 25 issues, by the Michigan State Medical Society as its official journal. Second class postage paid at East Lansing, Mich. and at additional mailing offices. Yearly subscription rate, $9.00; single copies, 80 cents. Additional postage: Canada, $1.00 per year; Pan-American Union, $2.50 per year; Foreign, $2.50 per year. Printed in USA. All communications relative to manuscripts, advertising, news, exchanges, etc., should be addressed to Publication Committee, Michigan State Medical Society, 120 West Saginaw Street, East Lansing, Michigan 48823. Phone Area Code 517, 337-1351. © 1970 Michigan State Medical Society.

* * *

MICHIGAN MEDICINE welcomes original scientific manuscripts, news items, photographs, features and letters presenting comments on issues. Authors may write to the MSMS Headquarters to obtain detailed instructions for the preparation of scientific papers.

SCIENTIFIC ARTICLES

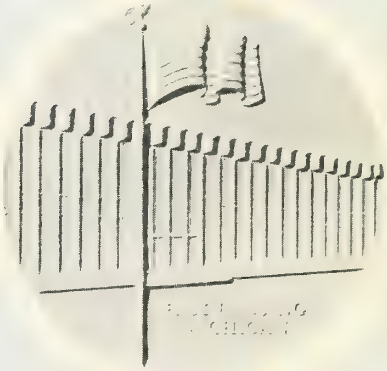
873 Mercury, Fish and Human Health; Thomas B. Eyl, M.D.; Kenneth R. Wilcox, M.D.; Maurice S. Reizen, M.D.
881 The Long-term Medical Care of the Stroke Patient; John Gilroy, M.D.
887 The Positive Approach to the Care of the Stroke Patient; Helen M. Millen, R.N.

SPECIAL ARTICLES

914 Michigan Health Council Places 999th and 1,000th Physicians in State
929 Role of Society of Pediatric Research; William B. Weil, Jr., M.D.
930 American Psychiatric Association Most Potent Force in Raising Status of Psychiatry; Raymond W. Waggoner, M.D.
932 Suicide Prevention in Detroit; Bruce L. Danto, M.D.
941 The Michigan Cancer Foundation's Role in the Third National Cancer Survey; Michael J. Brennan, M.D.; James F. Groen, M.A.

OTHER FEATURES

859 breaking news
866 welcome
868 msms leadership
869 officers' page
870 your opinion please
891 the viewbox
monthly surveillance report
892 perinatal tips
monthly surveillance report
911 msms news
913 mediscene
915 medical care programs
916 mailbag
921 about doctors
924 county societies
934 medico-legal
946 editorial viewpoints
950 ancillary
953 in memoriam
958 noted and quoted



MICHIGAN STATE MEDICAL SOCIETY
120 West Saginaw (P.O. Box 152)
East Lansing, Mich. 48823
Area Code 517, 337-1351

welcome

New Members

Wadi J. Jibrail, MD, 2912 S. State St., St. Joseph 49085

Larry L. Kompus, MD, 500 W. Huron St., Pontiac 48053

Harold Rodner, MD, 27078 Arden Park Circle, Farmington 48024

Glenn A. Rosin, MD, 149 S. Cranbrook Cross Rd., Birmingham 48010

Michel I. Salib, MD, 2928 Rambling Way, Bloomfield Hills 48013

Jerold W. Shagrin, MD, 28032 Selkirk, Southfield 48075

William G. Sills, MD, 1223 S. Washington, Royal Oak 48067

Milan Stojanovic, MD, 3535 W. 13 Mile Rd., Royal Oak 48072

Ted Vellenga, 3789 Wickham Drive, Muskegon 49441

J. Copner Webster, MD, 22000 Greenfield Rd., Oak Park 48237

24th AMA
Clinical Convention in
Boston, Massachusetts
November 29-December 2, 1970

WHAT'S NEW IN MEDICINE? Numerous scientific sessions at the AMA 24th Clinical Convention will provide the answers • Clinical Immunology • Clinical Gynecology • Pollution and the Physician • 3 Postgraduate Courses in Anesthesia, Burns, and Fluid and Electrolyte Balance • 9 Luncheon Round Tables • Renal Failure • Coronary Heart Disease • Drug Dependence • Complete program contained in October 19, 1970 JAMA Use the housing and registration forms in JAMA and the American Medical News to register in advance 24th Clinical Convention, American Medical Association, Boston, Massachusetts, November 29-December 2, 1970

DRUG ABUSE...

INTERNATIONAL SYMPOSIUM For PHYSICIANS

Towsley Center – University of Michigan Medical Center

November 9-13, 1970

...to help the physician cope more effectively with drug abuse in patient care, in the community, in schools, courts and social agencies...

...the complete spectrum of drug abuse: medical, pharmacologic, psychiatric, legal, social and philosophic...

Among the National and International Faculty are:

Dr. Thomas Bewley	England	Dr. Jerome Jaffe	Chicago
Dr. Henry Brill	New York	Prof. Abraham Kaplan	Ann Arbor
Dr. Dale Cameron	World Health Organization	Dr. Masaaki Kato	Japan
Dr. Henry Elliott	California	Daniel P. Moynihan	Washington, D.C.
Dr. Leonard Goldberg	Sweden	Dr. Maurice Seevers	Ann Arbor
Dr. Leo Hollister	California	Dr. Joseph Seifter	New York

For further information write to: Department of Postgraduate Medicine
The University of Michigan
Ann Arbor, Michigan 48104

Fast...long-lasting relief of aches and pains of colds and flu

with the unique timed-release aspirin

Double strength Measurin timed-release aspirin offers a new kind of control for your patients with cold and flu discomforts. In each 10-grain tablet are over 6,000 microscopic reservoirs that release aspirin at a controlled rate—some right away and some later on. This means fast relief of symptoms, followed by hours of comfort. Throughout the day, Measurin gives your patients freedom from a 4-hour aspirin schedule. During the night, its 8-hour dosage schedule holds the promise of sound sleep without awakening to take extra tablets.

For Professional Samples write:
Breon Laboratories Inc.
Sample Fulfillment Division
P.O. Box 141
Fairview, N.J. 07022

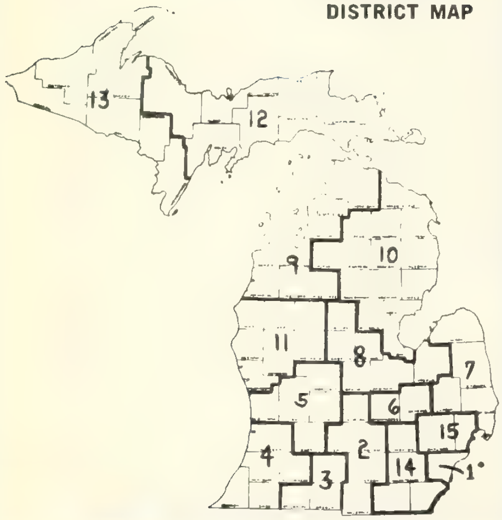
BREON **BREON LABORATORIES INC.**
90 Park Avenue, New York, N.Y. 10016
Subsidiary of Sterling Drug Inc.

MEASURIN®
TIMED-RELEASE ASPIRIN
ECONOMICAL • EFFECTIVE • LONG LASTING PAIN RELIEF
Dosage: 2 tablets followed by 1 or 2 tablets every 8 hours as required, not to exceed 6 tablets in 24 hours. For maximum nighttime pain relief, 2 tablets at bedtime.
Available: Bottles of 12, 36 and 60 tablets.

msms leadership

PRESIDENT	Robert J. Mason, M.D.	Birmingham
PRESIDENT-ELECT	Harold H. Hiscock, M.D.	Flint
SECRETARY	Kenneth H. Johnson, M.D.	Lansing
ASST. SECRETARY	Brooker L. Masters, M.D.	Fremont
TREASURER	John R. Ylvisaker, M.D.	Pontiac
ASST. TREASURER	C. Allen Payne, M.D.	Gd. Rapids
SPEAKER	James B. Blodgett, M.D.	Detroit
VICE-SPEAKER	Vernon V. Bass, M.D.	Saginaw
PAST PRESIDENT	James J. Lightbody, M.D.	Detroit
COUNCIL CHR.	Ross V. Taylor, M.D.	Jackson
VICE-CHAIRMAN	Ralph R. Cooper, M.D.	Detroit

COUNCILOR DISTRICT MAP



First District Councilors: (Wayne County)
Sidney Adler, MD, Detroit
Ralph R. Cooper, MD, Detroit
Don W. McLean, MD, Detroit
Milton R. Weed, MD, Grosse Pointe Park
Robert K. Whiteley, MD, Detroit

Second District Councilor: Ross V. Taylor, MD, Jackson
Counties: Clinton, Eaton, Hillsdale, Ingham, Jackson
Third District Councilor: Robert M. Leitch, MD, Union City
Counties: Branch, Calhoun, St. Joseph
Fourth District Councilor: Don Marshall, MD, Kalamazoo
Counties: Allegan, Berrien, Cass, Kalamazoo, Van Buren
Fifth District Councilor: John R. Pedden, MD, Grand Rapids
Counties: Barry, Ionia-Montcalm, Kent, Ottawa
Sixth District Councilor: Ernest P. Griffin, Jr., MD, Flint
Counties: Genesee, Shiawassee
Seventh District Councilor: John J. Coury, MD, Port Huron
Counties: Huron, Sanilac, Lapeer, St. Clair
Eighth District Councilor: A. Carl Stander, MD, Saginaw
Counties: Gratiot-Isabella-Clare, Midland, Saginaw, Tuscola
Ninth District Councilor: Adam C. McClay, MD, Traverse City
Counties: Grand Traverse-Leelanau-Benzie, Manistee, Northern Michigan (Antrim, Charlevoix, Cheboygan and Emmet combined), Wexford-Missaukee
Tenth District Councilor: Robert C. Prophater, MD, Bay City
Counties: Alpena-Alcona-Presque Isle, Bay-Arenac-Iosco, North Central Counties (Otsego, Montmorency, Crawford, Oscoda, Roscommon, Ogemaw, Gladwin and Kalkaska, combined)
Eleventh District Councilor: Brooker L. Masters, MD, Fremont
Counties: Mason, Mecosta-Osceola-Lake, Muskegon, Newaygo, Oceana
Twelfth District Councilor: William A. LeMire, Sr., MD, Escanaba
Counties: Chippewa-Mackinac, Delta-Schoolcraft, Luce, Marquette-Alger
Thirteenth District Councilor: J. Robert Franck, Jr., MD, Wakefield
Counties: Dickinson-Iron, Gogebic, Houghton-Baraga-Keweenaw, Menominee, Ontonagon
Fourteenth District Councilor: Harold F. Falls, MD, Ann Arbor
Counties: Lenawee, Livingston, Monroe, Washtenaw
Fifteenth District Councilor: Sydney Scher, MD, Mount Clemens
Counties: Macomb, Oakland

DIRECTOR
Warren F. Tryloff..........East Lansing
GENERAL COUNSEL
Lester P. Dodd.................Detroit
LEGAL COUNSEL
A. Stewart Kerr.................Detroit

ECON. CONSULTANT
Clyde T. Hardwick ....Detroit
HISTORIAN
Wm. J. Stapleton, Jr., MD ....Detroit
ASS'T HISTORIAN
Wm. M. LeFevre, MD ....Muskegon

SCIENTIFIC EDITOR
John W. Moses, MD ....Detroit

It's Time For MSMS To Provide Facts On Economics of Medical Practice

(Following are some excerpts from the address given by MSMS President Harold H. Hiscock, M.D., to the 1970 meeting of the MSMS House of Delegates.)

"The time has come for MSMS to move into the economic field if MSMS is to continue as the major force in medicine in this state.

"Our members are demanding this, which is evident, by the fact that a majority of specialty groups have had to do this for themselves. Such groups as pathology, radiology, internal medicine, urology, general practice, and a newly-formed emergency room group.

"It is evident to me that we can increase the value of the state society to its members if we:

"(1) Provide them with a current relative value fee schedule,

"(2) Provide them with information as to the cost of providing health care in various communities and,

"(3) Provide information as to how they can improve delivery of health care to their community.

"In the late 30s before the advent of the Tissue Committee doctors used to say, 'No one is going to tell me how to practice medicine.' But they did with the improvement in medical care. Now, doctors are saying 'No one is going to tell me how much I am going to charge my patients for my services.' Maybe in the near future an economic committee of doctors will change that to the betterment of our patients' and members' economic status.

"Our present MSMS relative value fee schedule should be updated as soon as possible. The various county medical societies should adopt annually their own conversion factor that will reflect the increase in living cost as well as increased costs of office overhead. Relative value fee schedules should reflect the usual customary fee of each of our counties. There should be no fixed state-wide fees that might be adequate in one area and substandard in some areas.

"I attended the meeting of State Presidents at the AMA meeting in Chicago last June. I met with Presidents from California, Washington, Connecticut, Indiana, Georgia and the District of Columbia. The question was raised, 'What is the actual cost of running our private offices?' We were all surprised that none of our organizations had little or any information on this subject.

"Yet if we are to answer the critics as to rising costs of medical care, this information should be available."

Harold H. Hiscock, M.D.
MSMS President

What is the medical profession's role in relation to the rock festivals of youth?

J. H. Ahronheim, M.D.
Jackson

When the rock festival of Goose Lake Park, held in Jackson County during the second weekend of August, was all over, the residents of the Goose Lake area breathed easier; the physicians of the county, who had been placed on alert, relaxed, and the emergency services of the hospitals went back to their normal routine. Miraculously, there was no major incident, and there were no acts of violence.

No one knows for certain how many youngsters had participated, the estimates running between 75,000 and 250,000. We were told that the sanitary facilities and food supply were reasonably adequate, whatever that may mean. The dominating features of the festival were nudism, open love making and, most of all, wide-spread distribution and use of drugs, primarily marijuana.

We, as physicians, must ask ourselves: What responsibility does the medical profession carry in gatherings of this sort?

The average citizen must ask himself: What is it that attracts young people to festivals such as that at Goose Lake? The youngsters will tell us that it is the type of music, which is offered, but also, what they call, togetherness.

The togetherness at Goose Lake was characterized by excessive hair and beard growth with the appropriate attire — the least objectionable —, by nakedness practiced by boys and girls, by open love making, and by unrestrained distribution and use of drugs.

That we as physicians hold a deep responsibility in this sort of gathering, should be indisputable. We can not stand by idly, while right under our noses basic medical principles are being violated, just because youngsters wish to do what normal parents would never permit them to do.

We become involved in a number of issues:

1. The physicians of the county, in which one of these festivals is to be held, should have the right to supervise the sanitary facilities and decide on their adequacy. They should have the right to inspect food supplies and eliminate those which they deem hazardous.

2. All medical facilities should be placed on alert, as was the case during the recent festival in Jackson County.

3. The physicians should have the opportunity to give advice to parents of youngsters, who plan on attending the festival.

The use of drugs concerns us physicians deeply. The medical profession has taken a leadership position in the fight against drug abuse, and certainly can not pass off the events at Goose Lake with a shrug of the shoulders.

As long as drug abuse is a feature of these festivals — and from the looks of things it appears that without drugs there would be no festivals — our advice to inquiring parents should be a categoric "No" to their children's participation. We must be prepared to counter the arguments in favor of drugs, as put forth by habitual users.

It must be stressed that we actually know very little about marijuana, and the little we do know, is still quite controversial. I have heard it said a number of times that "marijuana is no worse than alcohol"; what is not mentioned is that there is no substance which has caused as much misery as alcohol, which makes this a very poor argument indeed. If the parents still feel incapable of restraining their children from attending a festival, it would be our duty to instruct them on some of the basic principles of hygiene and sanitation, adding perhaps a lecture on venereal diseases and protection against them. We must impress on them that the children's immunization record be brought up to date, that they carry with them a first aid kit and a supply of non-spoiling food articles.

The individual county medical societies should go on record as to their stand on mass gatherings of this sort. If, as it is to be expected, they vote disapproval, this would discourage any interested entrepreneur and would strengthen the hand of a governmental authority, which is inclined to ban any festival of the Goose Lake type.

Richard C. Bates, M.D.
Lansing

As physicians, we are obligated to disapprove of rock festivals because of the risks they pose to health. At the same time, we must give all possible assistance to lower those risks, particularly those of contagion from hepatitis and venereal disease.

The most important health risks from attendance at rock festivals are probably not that normal youngsters will be subverted to the use of drugs. (Although they do, apparently, introduce some drug users to new modes of intoxication.) Nor, to the present, have there been epidemics, thanks, perhaps, to good fortune since multitudes share primitive eating, bathing and toilet facilities.

The greatest health risk is probably that of physical trauma. There is always likelihood of violence when thousands of immature, intoxicated and sociopathic adolescents gather in one spot. The violence that occurred recently in Chicago's Grant Park is only a sample of the damage that can occur when a mob becomes aroused. Sooner or later it is almost certain that mass carnage will occur.

I see little merit in physicians trying to "talk down" youngsters from "bad trips." It would appear that any attempt to turn a bad trip into a tolerable one might make the next venture into fantasyland more attractive. Certainly, we should be on hand to treat overdosage, respiratory arrest and trauma. The potential for mass casualties is such that medical communities in the vicinity of such a festival should be on stand-by disaster alert for its duration.

Since festivals are money-making enterprises I do not believe medical societies should offer free medical services to festivals, but organized medicine should help recruit individual physicians to work on the grounds. (Such recruits would be well advised to demand their pay in advance!)

If parents were ever to ask me whether their children should be allowed to attend a festival, I would tell them to forbid it which would probably spark an interesting discussion of the exercise of parental authority in that particular home. It's unlikely that this question will ever be asked: the parents of the sort of youngsters who attend rock festivals have generally lost all authority long before.

The phenomenon is probably short-lived. I'll predict that violent and criminal elements will shortly move in and spoil things. So it always is with innocent, "free," loose communal movements.

Kenneth J. Ray, M.D.
Grosse Ile

I have been asked to comment on my impression of rock festivals with particular reference to the giant one recently held at Goose Lake. I can think of no more appropriate time for such an observation. An earlier view of the attendent publicity might be too occlusive. A later view might be mellowed by time and distort a sordid experience of total irresponsibility to a legitimate experiment in communal living.

One cannot deny that life is generally enriched by a variety of experiences, good or bad, and that man has always felt a need to group in packs for reasons of safety, confidence, and courage. When that need is expressed in a sheltered atmosphere of permissiveness that seeks to evade the mores, not necessarily the laws of our society, it becomes suspect. Surely one does not have to behave as an animal to be enriched.

The motives of all participants in such a venture are clear. The promoters and performers seek only a financial gain. Morality plays no role in their participation. Money is the sole determinant. For the sincere spectator, the rock festival is an escape from reality. The males can commiserate with their fellow draft dodgers and perhaps burn a flag to demonstrate their lack of patriotism and scorn for mankind's political and social values. The dedicated female spectator can demonstrate her preoccupation with the inadequate and cowardly male. Perhaps she supports the women's liberation movement by demonstrating that "camp followers" still exist.

But all of these are a minority and the bulk of participants at such festivals are the curious young. These are the victims of exposure. For mankind gathering in groups is a great leveller, and youth in these circumstances sinks to its lowest common denominator. This is the great market for drug abuse and experimentation. The dedicated devotees of dangerous drugs have come well supplied. The ingenue is provided an opportunity to purchase and partake.

Purely from the health standpoint, rock festivals of the Woodstock and Goose Lake caliber provide little controversy. With inadequate food resources, poor water supply, and lacking sanitary facilities they are at best inflammatory — conducive to conjunctivitis, otitis, stomatitis, enteritis, and even urethritis. If a community can have all building permits banned because of poor sanitation surely our health departments can restrict the excessive congregation of people for the same reason.

(Continued on Page 897)

PINT (473 cc) M-148
Lilly
ILOSONE
LIQUID
ERYTHROMYCIN ESTOLATE ORAL SUSPENSION, U.S.P.
125
SHAKE WELL BEFORE USING
AVOID FREEZING
PINT 473 cc M 153
Lilly
ILOSONE
LIQUID
ERYTHROMYCIN ESTOLATE ORAL SUSPENSION, U.S.P.
250
SHAKE WELL BEFORE USING
AVOID FREEZING
Lilly
ILOSONE
125
ILOSONE
DROPS
Lilly
ILOSONE
CHEWABLE
125 mg.
100 PULVULES No 374
Lilly
ILOSONE
ERYTHROMYCIN ESTOLATE CAPSULES, N.F.
125 mg.
100 PULVULES No 375
Lilly
ILOSONE
ERYTHROMYCIN ESTOLATE CAPSULES, N.F.
250 mg.

Each 5 cc. contain
erythromycin estolate
equivalent to 250 mg.
erythromycin base.

When mixed as directed,
each 5 cc. will contain erythromycin
estolate equivalent to 125 mg.
erythromycin base.

When mixed as
directed, each cc.
will contain
erythromycin estolate
equivalent to 100 mg.
erythromycin base.

Each 5 cc. contain
erythromycin estolate
equivalent to 125 mg.
erythromycin base.

Each tablet contains
erythromycin estolate
equivalent to 125 mg.
erythromycin base.

Each Pulvule® contains
erythromycin estolate
equivalent to 125 mg.
erythromycin base.

Each Pulvule contains
erythromycin estolate
equivalent to 250 mg.
erythromycin base.

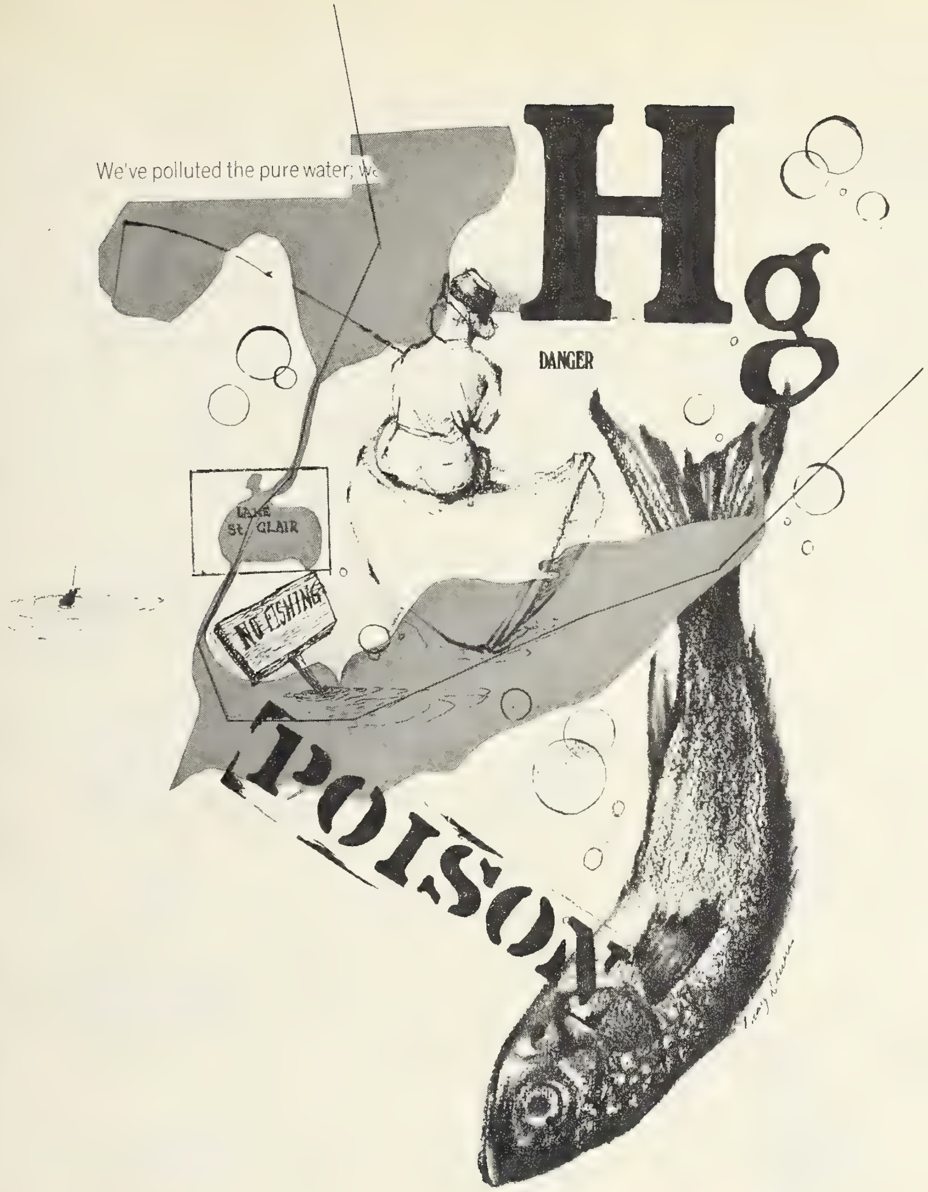
The many forms of Ilosone®

Erythromycin Estolate

Lilly

Additional information
available upon request.
Eli Lilly and Company
Indianapolis, Indiana 46206

900761



Mercury, Fish and Human Health

By Thomas B. Eyl, M.D.
St. Clair
Kenneth R. Wilcox, Jr., M.D., Dr.P.H.
Lansing
Maurice S. Reizen, M.D., M.S.P.H.
Lansing

Mercury and mercury compounds have been considered a major health hazard mainly in certain industries and in rare instances of accidental poisoning.

In April, 1970, mercury suddenly became the topic of acute concern because of the finding of mercury compounds in fish above the commonly accepted safe level.

For the most part, the medical profession was unprepared to evaluate this problem because the potential danger has only recently become known to the scientific community. The initial reaction of many physicians was based on their knowledge of common mercurials used in medications. By comparison, the dose of mercury compounds in fish seemed small. The recent scientific literature relating to the methyl-mercury compounds has not been available to the medical profession in general. This article summarizes the pertinent information concerning these mercury compounds to

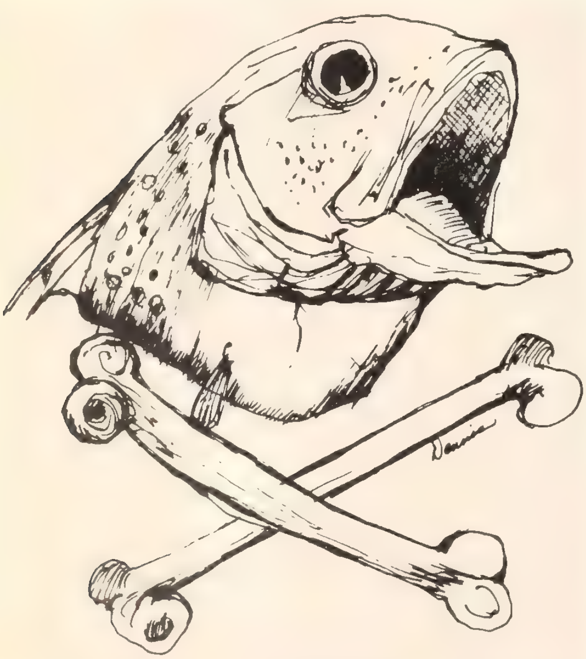
scientific papers

allow a more thorough evaluation of the problem. Physicians in the St. Clair area will be more likely to receive requests for information, although it is evident that the problem is more widespread than believed at first.

United States industry consumes approximately 6,000,000 lbs. of mercury per year; of this amount, 1,000,000 lbs. are used for treating seeds against mildew.[1] Canada uses up to 1,000,000 lbs. annually, of which 20,000 lbs. are used for treating seeds.[2] Other major industrial uses include the manufacture of electrical equipment, paper manufacturing, and the production of caustic soda and chlorine. Along the St. Clair River (outlet of Lake Huron), Lake St. Clair, Detroit River and Lake Erie are large "chloralkali" plants which, until recently, have discharged approximately 200 lbs. of waste metallic mercury into these waters daily. This estimate is based on approximately ½ lb. of mercury "lost" for each ton of chlorine produced.[2,3]

Mercury and Fish

In late March 1970, Canadian authorities informed the U. S. that fish taken from these waters contained an abnormally high mercury (Hg) level: up to 3.44 parts per million (ppm). Shortly thereafter, the Province of Ontario embargoed commercial fishing for walleye and perch. A sport-fishing ban was later declared but then removed. Michigan, Ohio, Wisconsin and New York soon enacted various types of similar bans, which for the most part were also removed. At this writing, the only remaining sport-fishing ban, in Michigan, has been modified to a so-called "catch and release" edict. Countless millions of dollars are being lost by commercial fishermen, sport-fishing resorts and equipment manufacturers, allied industries, and other affected individuals. The question of possible compensation for these losses is still pending. The Governor of Michigan has appointed an economic task force to determine the economic impact.



The first known instances of poisoning due to mercury in fish occurred on the Japanese island of Kyushu (Minamata Bay) from 1953 through 1960.[4,5,6] During this time, 111 persons were reported poisoned, with 44 recorded deaths, from eating shellfish contaminated by *methyl-mercury chloride* that had been discharged into the Minamata Bay and River by a plant producing plastics from vinylchloride and acetaldehyde. These shellfish contained an estimated 10 to 20 ppm of Hg. In Niigata, Japan, in 1964, a similar outbreak occurred along the lower Agano River, with 26 cases and five deaths officially documented; however, a total of 120 persons were affected showing *one or more* poisoning symptoms and an abnormally high blood level of Hg. Many of these Japanese cases died of *secondary infections* or exhaustion after showing definite poisoning symptoms.

Subsequent to the Japanese experience, a great deal of work has been done in Sweden on the *medical* aspects of mercury (Hg) contamination of fish. Sweden's largest lake (Lake Väner, 5,585 km^2, approximately 200 miles west of Stockholm), coastal waters for several hundred miles north and south of Stockholm, and parts of the straits between southern Sweden and Denmark, are among the restricted waters containing fish with from 0.5 to more than 1.0 ppm of mercury.[4]

Methyl-Mercury

The toxic substances in the fish are neither mercury itself, nor inorganic Hg compounds, such as Calomel, or $HgCl_2$, but organic compounds of Hg with methyl groups. Inorganic mercury is converted under anerobic conditions existing at the bottom of a large river or lake by the bacterium *Methanobacterium omelanskii* into organic *methyl-mercury* compounds,[7] hereafter abbreviated as "MM." The MM compounds are taken up by plankton and thus enter the food chain of fish.

Methyl-mercury compounds are readily absorbed by man and circulate in the blood stream unchanged, bound to the erythrocytes.[8,9,10] They dif-

---

Dr. Eyl has lived and practiced in St. Clair, Michigan for the last two years. He is now affiliated with Memorial Hospital of Warren, Michigan. Dr. Wilcox is Chief of the Bureau of Laboratories, Michigan Department of Public Health, and Dr. Reizen is Director of the Michigan Department of Public Health.

fuse slowly across the blood-brain barrier to the central nervous system so that in humans approximately 15% to 20% of the compound in the body is in the brain.[8,10] After exposure to toxic amounts there is a latent period of several weeks or months before symptoms appear.[8] Methyl-mercury intoxication cannot reliably be diagnosed by routine physical examination, blood tests or urinalysis. The MM compounds pass easily across the placenta, reaching levels in the fetus 20% to 30% higher than the maternal blood levels.[4,11] Developing fetuses and children seem to be more susceptible than adults.[6,11] These compounds have been shown to cause chromosomal breaks at relatively low levels.[12,13] Many other mercury compounds are excreted through the kidneys, but only 10% or less of MM is so excreted; most is excreted slowly through the intestinal tract.[8,9,10] From experience at Minamata and Niigata, plus accidental agricultural and industrial poisonings, and laboratory experiments with both animals and humans, MM compounds have been shown to have a half-life of approximately 70 days (excretion of approximately 1% per day).[8,9,10] This means that MM accumulates even if taken at weekly or longer intervals.

MM Poisoning

The signs and symptoms of MM intoxication are well established.[4,6,8,14,15] More or less in order of severity, they include:

a) *Neurasthenia*: feelings of weakness, excessive fatigue, inability to concentrate, headache, loss of memory for *basic* things, e.g., the alphabet, writing, spelling.

b) *Paresthesias*: numbness or tingling sensations of the mouth, lips, tongue; later, of hands, feet, fingers, toes.

c) *Ataxia*: difficulty in swallowing; inability to articulate words; loud, explosive speech; clumsiness with buttons, shoelaces and handling objects; stumbling gait; uncoordinated movements of body and limbs; inability to write or read; feeling of being "drunk."

d) *Concentric narrowing of visual field* with progressive loss of peripheral or "side" vision.

e) *Hearing difficulties,* especially when picking out one voice in a group.

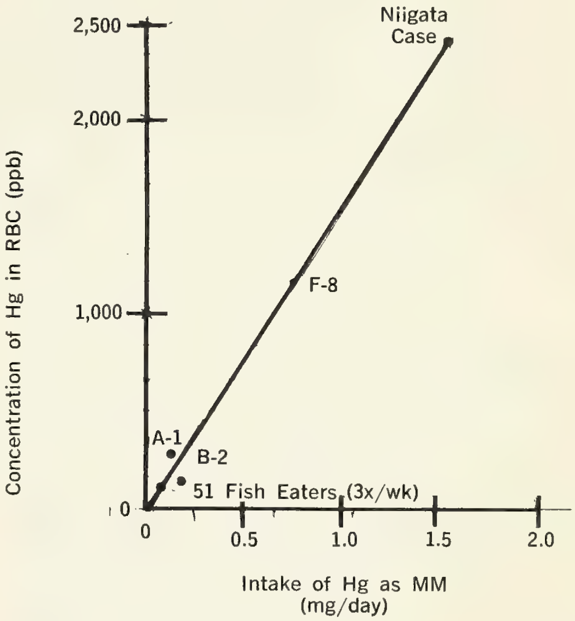
f) *Emotional instability*: violent, unpredictable outbursts of anger; fits of depression.

g) *Progressive loss of muscular control* with grotesque, wholly uncoordinated movements and, finally, flaccid paralysis.

h) *Death* in extreme cases.

FIGURE 1.

The Relationship Between Intake of Hg as MM and Concentration of Hg in Erythrocytes



Human Hg Levels

Tejning,[4,16] investigating normal human Hg levels, found values as low as 4.6 parts per billion (ppb) in RBC, 0.8 ppb in plasma, and 0.92 parts per million (ppm) in hair, in a 21-year-old man who *never* ate fish, and slightly higher blood values in an 80-year-old woman who *seldom* ate fish. Of 83 men and women who ate fish *at most* once a week, he found:

	RBC	*Plasma*
58 Men (average levels)	9.87 ppb	2.01 ppb
25 Women (average levels)	10.48 ppb	2.89 ppb

The average levels in plasma of women were statistically significantly higher. Similar findings have been reported by Birke, *et al.*[17] and by Sumari, *et al.* in Finland.[18]

Birke, *et al.*[4,17] and Tejning[4,16,19] have studied more than 160 Swedes who over a long period of time ate contaminated fish in varying amounts, from daily to once a week. The *daily Hg intake* of many of these persons was estimated from the frequency and amount of fish eaten and the measured Hg levels of the fish. **Table 1** is a *composite* of the results of these studies, arranged in order of ascending estimated daily Hg intake calculated from a careful study of the diets. Blood and hair values of the best-studied *fatal* Niigata case are included for the sake of comparison.

FIGURE 2.

The Relationship Between Intake of Hg as MM and Concentration of Hg in Erythrocytes

(Lower Left Corner of Figure 1 Enlarged)

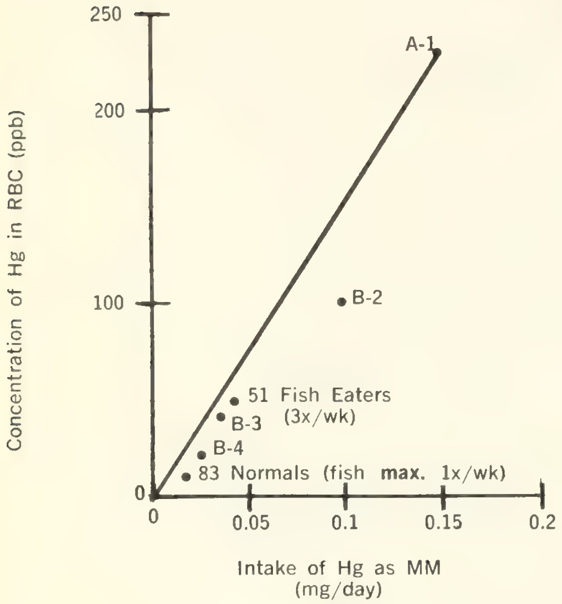
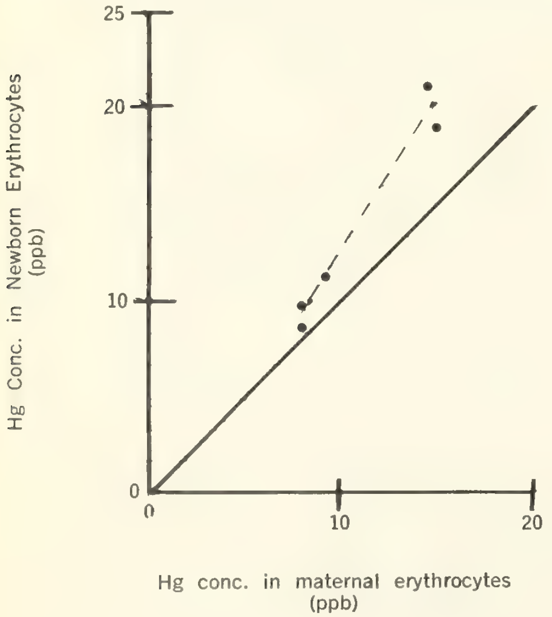


FIGURE 3.

Relationship Between Maternal and Newborn Erythrocyte Hg Levels



The linear relationship between daily Hg intake (mg) and RBC Hg level (ppb) can be shown graphically. In **Fig. 1**, a line is drawn through the points O, A-1 and F-8 given in **Table 1**. Extrapolation of the line to the Hg RBC level of 2,400 (1.85 x whole blood level of 1300) gives an estimated daily intake of 1.635 mg Hg for the case in Niigata. This corresponds to a daily meal of 250 grams of fish containing 6.5 mg/kg (ppm) of Hg. In **Fig. 2**, the lower left part of **Fig. 1** is enlarged, and, in order to verify the accuracy of the graph, points A-1, B-2, B-3, B-4 N (83 Normal persons: fish *max.* 1x/wk) and F (51 Fish Eaters—3x/wk) are added. They fit extremely well to the line, indicating that the slope is correct.[4]

Using similar methods, Birke, *et al.*[17] have also calculated the toxic daily intake of MM that might be fatal to be approximately *1 mg per day* [e.g., approximately 200 g. (6 oz.) of fish containing 5-6 ppm] for adult "heavy fish-eaters." One 14-year-old boy, during 10 days of July 1958, ate "a large number of shellfish" with an estimated minimum level of 10 ppm Hg from Minamata Bay. Three weeks later, typical Hg poisoning symptoms appeared; he was hospitalized, and in 1960 was still unable to continue his schooling because he could not remember the alphabet; his condition has remained essentially unchanged.[6] Tejning estimates that, with three fish meals per week, the MM content must not exceed 0.16 ppm in order to allow for a balance between intake and excretion and thus keep the blood levels below the normal recommended values.[4,19]

Allowable Levels of Hg In Fish

Determination of the allowable levels of Hg in fish to be used as food depends upon the amount of fish likely to be eaten, and the amount of MM measured as Hg that will avoid any reasonable possibility of harmful effects. Several methods for measuring the Hg content of fish are available that are accurate to a very small fraction of a ppm. These methods are based upon detection of Hg; but practically all Hg in fish is in the methylated form. Some examples of fish Hg levels in ppm (mg/kg) are as follows:

	ppm
a) International recommended limit for human consumption:	0.5
b) Estimated average of Väner Lake fish (Sweden):	0.87
c) Swedish official limit for human consumption:	1.0†
d) Fish taken from Lake St. Clair: *(one specimen had 6.65 ppm)*	*avg.* 104
e) Estimated average of Agano River (Niigata) fish:	5.0-20.0

---

† Probably based on a calculation error (too high, see following page)

TABLE I

Relationship of Hg Intake to Hg Levels in Humans

	Est. Hg Intake	Hg Concentration				
		Whole Blood	RBC	Plasma	Hair	Fish Eaten
	(mg/day)	(ppb)	(ppb)	(ppb)	(ppm)	(ppm)
83 Normals (avg.)	0.01		10.1	2.27		
Subject B-4	0.015	7	(13)*		2.2	0.5
Subject B-3	0.036	27	(50)*		8.7	0.5
51 Fish Eaters (avg.)	0.044		58	7.5	7.9	0.87
21 Fish Eaters (avg.)			59	7.2		
Subject B-2	0.1	53	(98)*		31.0	0.5
Subject A-1	0.15	125	223	26	40.0	0.5
Subject F-8	0.815	650	1,200	100	185.0	6.7
Niigata, Fatal Case	1.635	1,300	(2,400)*		500	10-20.0

* Calculated as 1.85 times the concentration in whole blood.

f) Measured levels of Minamata shellfish: 10.0-24.0*

g) Experimental lethal levels for V. japonica shellfish: ca. 20.0-30.0

According to Löfroth, the official Swedish limit of 1 mg/kg (ppm) has been widely criticized scientifically as being too high. It is probably based on an error in calculations, namely, the failure at first to realize that the Japanese fish levels were based on *dry weight* rather than wet weight. The *corrected* calculations using the approximate (*wet weight*) *lethal* value of 20 ppm for both shellfish found dead in Minatama Bay and experimentally cultured V. japonica, would be approximately as follows: According to pharmacological experience, decrease of the dose to 1/10 (2 ppm) would be expected to prevent the appearance of poisonings. It is customary to use a further safety factor of 1/10 of this "no effect" level when determining safe levels for substances in foods. With a further decrease to 0.2 mg/kg, one could reasonably expect to exclude adverse effects due to MM. The total "safety factor" of 100 used here (i.e., 1/100th of the lethal level for fish is considered to be reasonably safe for humans) *would not be considered adequate by some.*

Another method of estimating a safe level in fish is the consideration of mercury levels in exposed individuals.[8,10] One individual has been reported as having no symptoms despite a body mercury level *approximately one-half that found in a fatal Minamata case, or 650 ppb*. However, one suspected case of industrial poisoning with ethyl Hg compounds, reported elsewhere, had *the same* blood level of 650 ppb. There is no assurance that other individuals with levels this high would not be affected as in the industrial case. The best estimate of the asymptomatic person's daily Hg intake was approximately 0.8 mg. It is generally accepted that 1 mg per day of these compounds is enough to reach toxic levels in adults. If a safety factor of 1/10 below *this* "no effect" level is used, which would be a minimum, and less than usually used in establishing tolerance levels for foods, a daily ingestion of 0.08 mg per day or 0.56 mg per week would be considered the limit of safe intake. If the fish consumed contained 0.5 ppm of mercury, approximately 2.5 lbs. of fish could be ingested weekly; not many would exceed this amount. However, fish taken from the affected waters in the Lake St. Clair area might easily contain 2 ppm. Ingestion of only 10 oz. of such fish per week would be the limit, and this might be exceeded by many.

A third method of estimating a safe level in fish is the consideration of the concentrations required in the body to cause disease.[10] The critical concentration of mercury in the brain needed to cause disease has been estimated as being 8 ppm, although some patients who died in Minamata had *post-mortem* levels as low as 1 ppm. The total amount of mercury in the body required to reach 8 ppm in the brain is approximately 60 mg. Since the body excretes 1% of the compound per day, a daily dose of one-hundredth of this, or 0.6 mg would suffice to maintain this level. If one accepts, as a minimum, a safety factor of 10, the acceptable dose would be 0.06 mg daily or 0.42 mg weekly. If the fish ingested contained 0.5 ppm, the limit of ingestion should be less than two pounds per week. If fish with 2 ppm were ingested, the limit would be exceeded if more than one-half pound per week were eaten, which is not unlikely for many persons.

The general conclusion from these three methods of assessing a safe level of intake is similar. Based on estimated safety limits, the consumption of fish as a regular part of the diet containing less than the 0.5 ppm allowed by the Food and Drug Administration should not result in toxicity. Consumption of any significant quantity of fish above this level should be avoided.

---

* Many specimens found dead.

Other Effects Of MM

These toxicological considerations are aimed *primarily* at avoiding the appearance of *acute* poisoning symptoms. Even assuming that the safety factor in current use *may* be adequate, we are still playing "Russian roulette" with the possibility of long-term, sub-clinical effects, *particularly in regard to unborn children of pregnant mothers and possible genetic effects.* It has already been remarked that MM easily passes the placental barrier and *concentrates* in the fetus. Tejning reports that the average Hg levels in blood samples from five pregnant women and their newborn infants was 10.48 ppb in maternal and 13.42 ppb (28% higher) in infant erythrocytes.[11] Graphically, Tejning has also shown that infants of mothers with high Hg RBC levels had a *disproportionately* higher Hg RBC level (**Fig. 3**). The disproportionate fetal effects are borne out by the fact that of 19 Minamata and Niigata cases of congenital infantile cerebral paresis, the mothers showed little or no clinical neurological symptoms.[4,15]

When 0.1 mg MM-dicyandiamide, which is used in seed-treating preparations, was given intraperitoneally to either male or female inbred CBA mice (approximately ¼ to ⅓ the LD_{50}), a decreased fertility rate occurred. The same dose given on the 10th day of pregnancy resulted in a *high frequency of resorbed litters* and an *increased percentage of dead fetuses,* as follows:[4,20]

	No. Examined	No. Fetuses	% Dead Fetuses
Injected Females:	40	62	17.7
Controls:	90	683	7.2

MM has been shown in laboratory experiments to cause genetic damage at extremely low concentrations. In this respect, it is *1,000 times more potent* than the next most powerful agent known, colchicine. Ramel[12,20] has investigated the genetic effects of MM, which is active at extremely low doses (approximately 0.1 ppm or less). On root-tip cells of the onion plant *Allium Cepa,* so-called *"c-mitotic effects"* (i.e., spindles deformed; strong contraaction of chromosomes at metaphase; delayed centromere division; no anaphase), and *chromosome fragmentation* were observed. MM caused a so-called "meiotic drive" (i.e., doubling of sex chromosomes in some gametes, absence of them in others) in *Drosphila melanogaster* (fruit fly). *This effect was much stronger in females than in males.* MM compounds were observed to bind to and cause irreversible denaturation of DNA, with potential teratological and mutational implications. Ramel remarks that "there is no reason to believe that human cells *in vivo* would react differently." Thus, MM might cause syndromes such as Turner's, Down's or Klinefelter's. Fahmy[4,21] in 1951 reported similar cytological effects, stating that organic Hg compounds are 200 times more potent than inorganic ones for producing c-mitosis.

It has recently been shown that Swedish persons eating contaminated fish three times per week have a significantly higher frequency of lymphocyte chromosome breakage than normal persons.[13] The significance of this finding in terms of either teratogenicity or onchogenicity is not yet clear.

Findings In Michigan And Ontario

Limited studies have been performed on 20 individuals in Michigan eating fish from the Lake St. Clair area from twice weekly to twice monthly. Blood Hg levels on these individuals were from 7 ppb to 51.5 ppb with a mean of 17.8. The mean level for those who stopped eating these fish approximately 6 to 7 weeks before the blood was drawn was 14 and for those still eating the fish was 26.6. Thus, there appeared to be a definite effect of continued eating on the blood Hg level. Consideration of the excretion rate of these compounds would indicate that had both groups continued to eat these fish no difference in blood Hg level would have been seen. Urine Hg was very low in these persons and none was detected in nine of them. Hair has been obtained from some of them, but the analysis is not yet completed. *No persons having symptoms of MM intoxication have been found in Michigan to date.*

In Ontario, studies have been made on individuals having various degrees of exposure to affected fish. Some preliminary results are available from the Ontario Department of Health through Dr. E. Mastromatteo and Dr. R. B. Sutherland. Blood Hg levels of individuals without history of eating fish from contaminated waters were below 35 ppb. Persons eating fish from affected waters had blood Hg levels from 20 to 85 ppb with one individual having a level of 155 ppb. Hair Hg levels in persons not eating fish from affected waters were from 2 to 14 ppm. Persons eating fish from affected waters had hair levels as high as 96 ppm with one-fifth being more than 50 ppm. Urine Hg levels have been within normal limits. *To date, there have been no persons yet identified with symptoms of MM intoxication in Ontario.*

Discussion

The finding of methyl-mercury compounds in fish from the Lake St. Clair area has created a major problem related to the use of these waters, and other waters subsequently found contaminated, as a source of sport and commercial fishing. The first action must be to decrease the source of mercury. The involved manufacturing plants in the affected areas discontinued significant discharge soon after the full impact of the problem was known. It is estimated, however, that approximately 200,000 lbs. of Hg have been discharged into the mouth of the St. Clair River. Two methods have been proposed to handle this residue. Dredging may be feasible for removing a large portion of it. There is the danger, however, that the dredging operation will stir much material up, move it downstream and leave a major source of the problem. Dredging has been reported to be ineffective in Minamata Bay. Covering bottom deposits with crushed rock from ore tailings has been proposed in Sweden and has apparently been found effective there. The feasibility of this in the present situation has not been determined.

Summary

1) In the spring of 1970, fish taken from Lake St. Clair and the Detroit River were shown to contain significant levels of mercury. Methylated mercury compounds such as found in these fish have been shown to cause neurological disease (Minimata disease) in contrast to the type of toxicity caused by inorganic compounds usually associated with mercury intoxication.

2) With the exception of Japan, where highly contaminated fish formed a large portion of the daily diet, no known cases of clinically evident poisoning from methylmercury-contaminated fish have been reported to date.

3) Because of the demonstrated, potentially catastrophic danger to the fetus, **pregnant women should not eat MM-contaminated fish,** even in very small quantities.

4) **Genetic damage** (chromosome fragmentation and c-mitosis) caused by MM at levels of less than 0.1 ppm has been demonstrated on plants and insects. Preliminary reports indicate an abnormally high frequency of lymphocyte chromosome breakage among persons eating 3 meals of fish containing 1 to 7 ppm MM weekly for more than 5 years. Further investigation is urgently needed.

5) **A daily intake of 1 mg Hg** in the form of MM (corresponding to approx. ½ lb. of fish containing 4 ppm), continued for any significant length of time, **could easily be fatal.**

6) The recommended limit for mercury in food is **0.5 ppm, and the maximum** "safe" ADI (Allowable Daily Intake) of Hg in the form of MM is thought to be 0.1 mg (corresponding to 100 Gm of fish containing 1 ppm — approx. ¼ lb.; or about 1½ lbs. per week. **Even this safety factor may not be adequate.**

7) Various human blood and hair levels of Hg as MM (summarized):

	Whole bld. (ppb)	RBC (ppb)	Hair (ppm)
a) Normal levels:	5	10	10
b) Est. **maximum** "safe" level:	50	100	—
c) Est. **overt** symptoms level:	500	1,000	150
d) **Fatal** level of Niigata case:	1,300	2,400	500

8) Direct discharge of Hg into the affected waters has been stopped, but to date no solution has been found to remove or bind the mercury still present.

References

1. Kolbye, A.: Bureau of Foods, Pesticides and Product Safety, USFDA: Public Statement, Mt. Clemens, Michigan, May, 1970.
2. Fimreite, N.: Mercury Uses in Canada and their Possible Hazards as Sources of Mercury Contamination. Pesticide Sect. Canad. Wildlife Service, Manuscript Reports. No. 17, 1969.
3. The Man Who Shocked Two Nations. Canad. Consult. Eng. 32-35, June, 1970.
4. Lofroth, G.: Methylmercury (A review of health hazards and side effects associated with the emission of mercury compounds into natural systems). Swedish Natural Science Research Council monograph, March 20, 1969.
5. Irukayama, K.: The Pollution of Minamata Bay and Minamata Disease. Third Int. Conf. on Water Pollution Research, Munich, Sect. III, Paper #8, 1966. Water Pollution Control Fed., Wash., D.C. 20016.
6. Kurland, L.T.; Faro, S.N. and Siedler, H.: Minamata Disease. *World Neurology I.* 370-391, 1960.
7. Wood, J.M.; Kennedy, F.S. and Rosen, C.G.: Synthesis of Methyl-mercury Compounds by Extracts of a Methanogenic Bacterium. *Nature, 220:* 173-174, 1968.
8. Maximum Allowable Concentrations of Mercury

Compounds. Report of an International Committee. *Arch. Environ. Health. 19*:891-905, 1969.

9. Aberg, B.; Ekman, L.; Falk, R.; Greitz, U.; Persson, G. and Snihs, J.: Metabolism of Methyl Mercury (^{203}Hg) Compounds in Man. *Arch. Environ. Health. 19*:478-484, 1969.
10. Miller, M.W. and Berg, G.G.: Chemical Fallout: Current Research on Persistent Pesticides. Published 1969. Library of Congress Catalog Card No. 69-19178.
11. Tejning, S.: Kvicksilverhalterna i Blodkroppar och i Blodplasma Hos "Normala" Modrar och Deras Nyfodda Barn. Report 68 02 20 from Occupational Medicine Clinic, Univ. Hosp., Lund, Sweden.
12. Ramel, C.: Methylmercury as a mitosis disturbing agent. *J. of Jap. Med. Assn. 61*:1072-1077.
13. Skerfving, S.; Hansson, K. and Lindsten, J.: Chromosome Breakage in Humans Exposed to Methyl Mercury Through Fish Consumption. *Arch. Environ. Health. 21*:2, 133-139, 1970.
14. Hook, O.; Lundgren, K.-D. and Swensson, A.: On Alkl Mercury Poisoning. *Acta Med. Scand. 150*: 131-137, 1954.
15. Matsumoto, H.; Koya, G. and Takeuchi, T.: Fetal Minamata Disease. *J. of Neuropathol. and Exp. Neurol. 24*:563-574, 1965.
16. Tejning, S.: Kvicksilverhalterna i Blodkroppar och i Blodplasma Hos Vuxna Normalpersoner. Report 67 02 06 from Occupational Medicine Clinic, Univ. of Lund, Sweden.
17. Birke, G.; Johnels, A.; Plantin, L.O.; Sjostrand, B. and Westermark, T.: Metylkvicksilverforgiftning genom fortaring av fisk? *Svenska Lakartidningen, 64*:37, 3628-3637, 1967.
18. Sumari, *et al.*: Health Investigations of Fish Consumers in Finland. Nord. Hyg. Tidskrift, 1968-69.
19. Tejning, S.: Kvicksilverhalterna i Blodkroppar och i Blodplasma Hos Storkonsumenter av Kommersiell Saltvattenfisk. Report 68 05 29 from Occupational Medicine Clinic, Univ. of Lund, Sweden.
20. Ramel, C.: *Hereditas. 57*:445, 1967.
21. Fahmy, F.Y.: Ph.D. Thesis, Institute of Genetics, Univ. of Lund, Sweden, 1951.

Acknowledgement

Grateful acknowledgement is made to Norvald Fimreite, Ph.D., and colleagues at the University of Western Ontario in London (Ontario), without whose generous assistance in furnishing references and background material this article could not have been written.

On May 7, 1970, a symposium on stroke was held at Cobo Hall in Detroit under the auspices of the Michigan Heart Association. The materials presented are felt to be of sufficient interest to all members of our society to present them in *Michigan Medicine.* Two of the articles are presented herewith. In subsequent issues the following articles will be presented: "The Evaluation and Treatment of Aphasic Patients," by Harlan Bloomer, Ph.D.; "Organizing the Community Hospital for Stroke," by Frederic B. House, M.D., and John J. Freysinger, M.Ba., M.P.H., and "Care of the Stroke Patient Does Not Stop in Discharge from the Community Hospital," by Florence Parker, R.N. — John W. Moses, M.D., MSMS Scientific Editor

The Long-term Medical Care Of the Stroke Patient

By John Gilroy, M.D., F.R.C.P. (C)
Detroit

The acute stroke can no longer be regarded as a disease entity presenting as a sudden and often unexpected episode in a patient's life.

It is in fact a new development in the long and continuing degenerative process of chronic cerebrovascular disease. This process is essentially insidious and progressive and is active before, during and after the stroke.

The long term medical care of the stroke patient is directed towards the prevention of further development of cerebral arteriosclerosis and at best can only delay the progression of this condition.

It should begin with the diagnosis of cerebrovascular insufficiency which can be made in some patients who present with transient ischemic attacks. Unfortunately, such cases are in the minority and the acute stroke is the first indication of cerebral arteriosclerosis and cerebrovascular insufficiency in the majority of patients.

This means that long term medical care should be planned and initiated during the treatment of the acute stroke.

There are a number of factors which are believed to contribute to the development of cerebral arteriosclerosis which should be recognized and treated during and after the acute episode. In addition, a number of other factors have been recognized which are not directly atherogenic but which may act to precipitate a stroke. These conditions should be controlled or eliminated to reduce the risk of another stroke.

Factors contributing To accelerated arteriosclerosis

The term "arteriosclerosis" is used in a broad sense to include atherosclerosis affecting large and medium sized arteries, hyperplastic arteriosclerosis of medium sized vessels and obliterative arteriosclerosis involving the smaller cerebral arteries. Factors known to contribute to the development of arteriosclerosis are listed in **Table I.**

Table I

Factors leading to accelerated arteriosclerosis:

1) Hypertension
2) Diabetes Mellitus
3) Obesity
4) Hyperuricemia
5) Hypothyroidism
6) Abnormal serum lipid levels
7) Smoking

1) Hypertension

Chronic hypertension is one of the major factors in the pathogenesis of arteriosclerosis. It appears to accelerate the arteriosclerotic process in cerebral, coronary and peripheral vessels.[1-4] When these conditions are considered, however, the hypertensive patient shows an excess risk of stroke compared to myocardial infarction or peripheral vascular insufficiency. The term "hypertension" is somewhat ambiguous when applied to studies of patients with cerebrovascular disease in that there is no sudden change in the incidence of cerebrovascular disease related to systolic blood pressure levels. There is a steady increase in the risk of stroke with increased levels of systolic blood pres-

---

Doctor Gilroy is professor and chairman, Department of Neurology, Wayne State University.

sure and there is no firm dividing line between "normotensive" and "hypertensive" individuals.

Many patients with chronic cerebrovascular disease present with labile hypertension and casual measurements of blood pressure may give an erroneous impression of systolic levels which fall in the so-called normotensive range. These patients are nearly all susceptible to considerable rise in systolic blood pressure in response to stress and if this condition is detected, it should not be regarded as a reaction to a stressful situation which is of little importance. It is quite likely that patients with this type of response have many periods of hypertension during the day and that this type of hypertension can also contribute to accelerated arteriosclerosis. To simplify matters, it may be said that all hypertension should be treated as soon as it is detected in the patient with cerebrovascular disease.

2) Diabetes Mellitus

A survey of the stroke population in some stroke centers using the glucose tolerance test revealed an incidence of more than thirty per cent of patients with diabetes mellitus.[3-7] Many of these cases are mild, suggesting that patients develop the other metabolic abnormalities of diabetes mellitus without marked changes in glucose metabolism as indicated by glusoce tolerance test. It is also possible that the incidence of an abnormal glucose tolerance curve would be higher in the stroke population if there was a reliable provocative test. However, provocative tests have not yet been developed for use in the elderly and the true incidence of diabetes mllitus has not yet been determined. The risk of stroke is increased when diabetes is associated with hypertension and this combination appears to be a potent cause of accelerated arteriosclerosis. There is no evidence to show that accelerated arteriosclerosis is more common in the severe diabetic than in the mild diabetic nor that strict control of diabetes mellitus reduces the risk of developing a stroke.

3) Obesity

While there is little direct evidence linking obesity and increased predisposition to stroke, there may be an indirect relationship between these two conditions. Both hypertension and overt diabetes mellitus are commoner in obese patients and are potent reasons for weight reduction in a stroke prone individual.

4) Hyperuricemia

A number of independent studies have indicated a relationship between hyperuricemia and chronic cerebral arteriosclerosis.[8-10] Hyperuricemia is usually asymptomatic and patients rarely have symptoms of gout. They do, however, show an increase in stenosis of extracranial vessels in the neck rather than generalized arteriosclerotic changes in intracranial vessels. The significance of the hyperuricemia in the pathogenesis of atheromatous plaques in the carotid and vertebral arteries is not clear. It has been suggested that urate deposits in the intima act as a nidus for the concentration of lipid material and development of atheromatous plaques.[11] Another hypothesis states that uric acid acts as a powerful cationic agent attaching itself to cholesterol and bringing the cholesterol into contact with the intima.[12]

5) Hypothyroidism

There is some disagreement on the incidence of hypothyroidism in the stroke population. However, there is no doubt that hypothyroidism may be a factor in the pathogenesis of arteriosclerosis in some cases. All patients who have abnormalities in protein bound iodine levels should have full evaluation of thyroid function.

6) Abnormal serum lipid levels in cerebrovascular disease

The relationship between abnormal serum cholesterol levels and atherosclerosis was first demonstrated by Anitschkow in 1913.[13] Since that time, abnormalities in lipid metabolism have been regarded as one of the primary factors in the development of arteriosclerosis. Subsequent studies have shown that in addition to elevated serum cholesterol levels,[14] there are increased triglyceride levels[15] and abnormal lipid protein patterns in patients with arteriosclerosis.[16]

The work showing a positive correlation between abnormal serum lipid levels in arteriosclerosis has, for the most part, concentrated on coronary artery disease rather than cerebrovascular disease. A number of papers have, however, been published in which the role of lipid metabolism in cerebral arteriosclerosis has been discussed. These articles have been equivocal.

The majority of papers report that there is no statistically significant correlation between serum lipid levels and cerebral arteriosclerosis in chronic cerebrovascular disease.[17-21] However, the long term Framingham study revealed a definite association between increased serum cholesterol levels and incidence of stroke in patients under 50 years of age.[22] A study carried out within one year of an acute stroke in patients in all age groups has shown that serum cholesterol levels are not significantly elevated during this period.[23] There is also some ambiguity in results obtained from the study of serum lipid levels immediately following the acute stroke. Levels have been reported as elevated and within normal limits.[24-26] It seems possible that if serum lipid levels are measured within a few days of the acute episode, that abnormalities may be detected and that there may be a tendency for these abnormalities to decrease within a month of the stroke.[27]

7) Smoking

The establishment of an association between smoking and cardiovascular disease is not so apparent in patients with cerebrovascular disease. Nevertheless, figures published from the Framingham study do indicate an increased risk of stroke in those who smoke as compared to the non-smokers.[1-2]

Factors Other Than Arteriosclerosis Which May Contribute To The Onset Of An Acute Stroke

1. Cardiac Arrhythmias, Congestive Heart Failure and Electrocardiographic Abnormalities

There is a high percentage of electrocardiographic abnormalities in patients with cerebrovascular disease and these are associated with a marked excess risk of stroke. This implies a close relationship between heart disease and the development of stroke. Thus, patients with a history of myocardial infarction, hypertensive arteriosclerotic heart disease and congestive heart failure are in the high risk category in the potential stroke population.[2,7] Some 10 per cent of patients with acute stroke have associated acute myocardial infarction while over 50 per cent of patients with cerebrovascular disease have electrocardiographic changes compatible with arteriosclerotic heart disease.[3,7]

The association of acute myocardial infarction and acute cerebral infarction is frequently unrecognized because of the inability of the patient to give an adequate history at the time of the stroke.

There are a number of reasons for this association. It is possible that an antecedent myocardial infarction may be followed by a stroke because of a suddent fall in blood pressure which is not compensated for by cerebral autoregulation, the resultant cerebral ischemia leading to cerebral infarction. Patients with myocardial infarction are prone to episodic arrhythmias which can decrease cardiac output and reduce cerebral blood flow. There was also a risk of cerebral embolism from mural thrombi arising at the site of a myocardial infarction, particularly during periods of changing rhythm.

2. Syphilis

About 5% of patients with an acute stroke have active meningovascular syphilis. This is a fairly constant figure and is likely to remain so for many years. Syphilis is a potent cause of stroke in younger patients, often resulting from the occlusion of a major vessel which is the site of syphilitic arteritis producing extensive infarction of the brain.[28]

Table II

Factors other than arteriosclerosis
which may contribute
to the onset of an acute stroke.

1) Cardiac arrhythmias, congestive heart failure and electrocardiographic abnormalities.
2) Syphilis
3) Polycythemia
4) Hypercoagulable state
5) Postural hypotension
6) Kinking and compression of extracranial vessels
7) Embolism

3. Polycythemia

A small percentage of patients with acute stroke have a true polycythemia vera. This condition is associated with increased circulating blood volume and an absolute erythrocytosis. Polycythemia is associated with decreased cerebral blood flow and an increased tendency to thrombosis.[29,30] A relative polycythemia due to dehydration is not uncommon in patients with acute stroke but responds to fluid replacement. A polycythemic reaction has also been recorded in some patients following the acute stroke and may be due to a direct influence on erythropoetic tissue activity by disturbed centers in the central nervous system following the acute stroke.[31] If this is so, it raises new considerations in the treatment of the acute stroke since polycythemia is a potent cause of reduced cerebral blood flow which in itself could result in further ischemia and spreading of infarction.

4. Hypercoagulable state

The term "hypercoagulable state" is used to indicate an increased tendency to clotting which occurs in many patients with an acute stroke. Many factors may be involved. Elevated fibrinogen levels have been demonstrated in patients with cerebrovascular disease[32] and there is increased activation of platelets, particularly during the first few days following an acute stroke.[33] Platelet activation may lead to platelet aggregation and platelet emboli which impede cerebral circulation.[34] Platelet activation in chronic cerebrovascular disease may be a factor in the development of transient ischemic attacks. However, platelet activity in chronic cerebrovascular disease is not marked when compared to the striking changes seen in the acute stroke.[35]

5. Postural Hypotension

Many patients with cerebrovascular disease exhibit quite a marked fluctuation in blood pressure. This has been demonstrated by continuous monitoring of blood pressure in patients with an acute stroke and with chronic cerebrovascular conditions. The hypothesis that intermittent hypotensive episodes precipitate transient ischemic attacks or result in cerebral infarction in patients with chronic cerebrovascular disease has not been borne out by recent observations.[30] Patients with cerebrovascular insufficiency do not develop transient ischemic attacks when the blood pressure is lowered artificially with the use of antihypertensive agents and the use of a tilt-table.[36-38] Attacks of cerebrovascular insufficiency are uncommon in patients who receive anti-hypertensive drugs despite the fact that many of these patients develop hypotensive episodes in the early days of treatment. Similarly, transient hypotension is not uncommon in the elderly during surgical procedures and yet rarely results in cerebral infarction. Such observations support the conclusion that transient hypotension is not a major factor in the pathogenesis of the transient ischemic attack or cerebral infarction. Nevertheless, hypotensive episodes may be important if associated with other factors already discussed above and cannot be dismissed as entirely non-significant. A small group of patients with hypotension and cerebrovascular disease have pituitary adrenal insufficiency which responds readily to substitution therapy.[39]

6. Anemia

Transient ischemic attacks have been described in patients with marginal cerebral blood flow and anemia. These readily respond to treatment of the anemia with cessation of these attacks.

7. Kinking or compression of extracranial vessels

The internal carotid and vertebral arteries may undergo kinking or compression in the neck with head turning. This results in reduction or cessation of flow through the affected vessel. Arteriosclerotic vessels in the neck lose elasticity and frequently lengthen, resulting in the formation of redundant coils or actual kinking of the vessel. The sites of kinking or coiling may undergo marked stenosis when the head is turned.[40] Some patients have congenital coiling of the internal carotid arteries which do not produce any symptoms in the healthy patient but which may be the site of kinking and stenosis on head turning following arteriosclerotic changes later in life. External compression of the cervical vessels has also been demonstrated on head turning. The internal carotid artery can be narrowed or occluded by the lateral mass of the atlas when the head is turned to the opposite side.[41] This may result in the production of carotid insufficiency. The vertebral arteries are frequently compressed on head turning by osteophytes arising along the margins of the cervical vertebrae and intrapeduncular joints. These osteophytes tend to encroach upon the vertebral artery as they pass through the foramina in the transverse processes of the cervical vertebrae and compression of the vessels may be exaggerated by head turning resulting in symptoms of vertebral basilar insufficiency.[42-45]

8. Embolism

It is possible that the role of embolism in relation to transient ischemic attacks and cerebral infarction have been underestimated in the past. As already stated, some ten per cent of patients with acute stroke have concommitant acute myocardial infarction and it is reasonable to assume that cerebral infarction, in some of these cases, is secondary to emboli originating from a mural thrombus in the heart. The recorded high incidence of cardiac arrhythmias in the stroke population suggests that cerebral embolism is a major factor in transient ischemic attacks or acute cerebral infarction due to emboli originating in the auricles and breaking free during a change in rhythm.

Emboli can also arise in other parts of the circulatory system and travel to the brain. Autopsy evidence would indicate that fresh thrombus formation over arteriosclerotic plaques at the origin of the internal carotid or vertebral arteries in the neck may be responsible for embolism and acute stroke in some cases.[30]

Patients with transient ischemic attacks have a high incidence of significant plaque formation in the cervical vessels.[46-48] Autopsy studies in the patients have shown that the thrombus in the intracranial vessels is laminated in many cases, suggesting that it has developed gradually by increments over a considerable period of time.[30]

Patients with transient ischemic attacks sometimes show emboli in the retinal vessels which are readily recognized with the ophthalmoscope.[49] In some cases, they appear as bright, highly refractile bodies, suggesting that they arise from a fragmented plaque in the internal carotid artery. In other cases, they appear as an irregular white or translucent area within the vessel. This second type of embolus usually disappears and they probably originate as platelet emboli which break free from arteriosclerotic plaques in the neck and undergo further fragmentation in the retinal vessels.

It is interesting to note that both transient ischemic attacks and stroke have followed the carotid compression test or manipulation of the carotid sinus in the neck.[50] Such cases have occurred without observed bradycardia or hypertension during carotid artery manipulation.

Acute stroke is also an unfortunate but infrequent complication of carotid arteriography.[51] This has only occurred with the direct technique when the carotid artery under study has been punctured in the neck. It is not a complication of indirect arteriography using the retrograde transbrachial route. This suggests that the needle dislodges atheromatous material in the carotid artery or that it is the site of platelet aggregation with subsequent embolization into the cerebral circulation.[52]

The Medical Care Of the Stroke Patient

Medical care may be divided into two phases. The first, the care of the acute stroke, is beyond the scope of this paper. In brief, it is a period of active medical and nursing care in which the patient receives a high standard of treatment. There is no reason why treatment of the acute stroke should not receive the priorities given to the treatment of the heart attack with the development of specialized units for this purpose. The cerebral infarction is equally as devastating and potentially more disabling than the myocardial infarction, but the medical priorities for stroke are low and will not change until the fallacy of "you can't do anything for stroke" is eradicated.

The second phase of medical care for the stroke patient is the long term management directed towards the goal of obtaining the maximum degree of recovery and the prevention of further attacks.

Rehabilitation of the stroke patient begins on the first day with passive movements of all limbs, turning every two hours to prevent the development of decubiti and maintaining the paralyzed limb in the optimum position of function. This is accomplished by use of a foot board to prevent foot drop and contraction of the tendon Achilles; a sandbag to prevent external rotation at the hip; the maintenance of a functional position of the hand with a hand roll and the use of a pillow in the axilla to prevent an adduction deformity of the upper limb.

These measures are followed by a program of rehabilitation designed to restore the patient to full acitvity in the community. All available skills including physical therapy, occupational therapy, speech therapy, vocational rehabilitation, visiting and public health nursing services and social service should be utilized when available and these services should be coordinated by the patient's physician whose interest is the key to successful treatment.

At the same time, the physician can begin a thorough evaluation of the patient to detect medical abnormalities which contribute to the continued development of cerebral arteriosclerosis or which may precipitate another stroke. The investigation of the patient covers all the factors mentioned in this article **(Table 3)** and treatment should begin during the period of acute care since many of these abnormalities are detrimental during the acute period and may increase the severity of the stroke.

Table 3

Investigation of a Patient With Cerebrovascular Disease

1) Complete blood count and serology.
2) Urinalysis.
3) Blood urea nitrogen.
4) Two hour post-prandial blood sugar. If abnormal, 5 hour glucose tolerance test.
5) Serum uric acid
6) Protein bound iodine. If abnormal, radioactive iodine T_3 or T_4 tests.
7) Electrocardiogram.
8) Central venous pressure and circulation time if there are clinical signs of heart failure.
9) X-ray chest, skull, cervical spine, including oblique views of cervical spine.
10) Record blood pressure every hour for 24 hours. Record every 4 hours when patient begins to ambulate.
11) Serum lipid-lipoprotein levels when available.
12) Test for pituitary-adrenal insufficiency in patients showing persistent hypotension.
13) Lumbar puncture in cases where subdural hematoma or brain tumor cannot be ruled out.
14) Electroencephalogram.
15) Arteriography in patients who may have stenotic lesions in the neck vessels (bruits in the neck on auscultation) or where subdural hematoma or brain tumor are suspected.

It is, however, equally important to continue the long term care of the patient. The physician must think in terms of preventative medicine and insist on re-evaluation of the patient at regular intervals. Treatment of the various medical conditions seen in the stroke patients is all too frequently intermittent or partial. It is not infrequent, too, to see patients who are receiving medication for the control of hypertension who are still frankly hypertensive or who exhibit hypertension under mild stress. This is an example of insufficient treatment which is probably of little benefit to the patient in the long term.

There is need to develop a positive attitude toward preventative medicine in the medical profession in the treatment of cerebrovascular disease. It is interesting to note that reports of the effectiveness of blood pressure control in stroke survivors are now beginning to appear and are encouraging.[53]

It is possible that the approach to stroke and cerebrovascular disease outlined here will produce better long term results in the stroke population. There is no doubt that patients can be restored to an active productive life in many cases with realistic allowances made for residual disability. The aim is to keep the patient with chronic cerebrovascular disease in this category. The alternative is a chronically debilitated, poorly functioning patient, subject to further episodes of cerebral infarction, leading to chronic dementia and obligatory institutional care. The time and skill invested in avoiding this situation will be amply rewarded by the reduction of the morbid effects of chronic cerebrovascular disease.

References

1. Kannel, W.B. An epidemiologic study of cerebrovascular disease, in *Cerebral Vascular Diseases,* Transactions of the Fifth Conference, Princeton, New Jersey, edited by C. H. Millikan, R. G. Siekert and J. P. Whisnant. New York, Grune and Stratton, 1966, pp 53-66.
2. Kurland, L.T., Choi, N.W., and Sayre, G.P. Current status of the epidemiology of cerebrovascular diseases in *Stroke Rehabilitation, Basic Concepts and Research Trends.* Compiled and edited by William S. Fields and William A. Spencer, St. Louis. Warren H. Green, Inc., 1967, pp 3-30.
3. Gilroy, J. and Meyer, J.S. Cerebrovascular diseases in *Medical Neurology,* New York, Macmillan Co., 1969, pp 477-554.
4. Meyer, J.S. Newer concepts of cerebral vascular disease. Med. Clin. North America, 54, 349-360, 1970.
5. Meyer, J.S. Acute stroke. Biochemical and therapeutic studies. Minn. Med., 47, 265-271, 1964.
6. Millikan, C.H. The stroke prone profile. Current concepts of cerebrovascular disease. Stroke, 4, 17-20, 1969.
7. Bauer, R.B. Evaluation of the stroke patient with respect to associated diseases in *Stroke Rehabilitation, Basic Concepts and Research Trends.* Compiled and edited by William S. Fields and William A. Spencer, St. Louis. Warren H. Green, Inc., 1967, pp 31-38.
8. Meyer, J.S., Kypros, G.P., and Gilroy, J. Hyperuricemia, gout and cerebrovascular disease. West Virginia Med. J., 60, 150-153, 1964.
9. Heiskanen, O.E. Multiple intracranial arterial aneurysms. Acta Neurologica Scand., 41, 356-62, 1965.
10. Pearce, J. and Aziz, H. Uric acid and plasma lipids in cerebrovascular disease. Part I. Prevalence of hyperuricemia. Brit. Med. J., 4, 78-80, 1969.
11. Trout, E. F., Knight, A.A., and Szanto, P.B. Specific vascular changes in gout. J.A.M.A. 156, 591-596, 1954.
12. Gertler, M.M., Garn, S.M., and Levine, S.H. Serum uric acid in relation to age and physique in health and coronary heart disease. Annals of Internal Medicine, 34, 1421-1431, 1957.
13. Anitschkow, N. and Chalatow, S. Uber experimentelle cholesterinsteatose urd ihre Bedentung fur die Entstelung einiger pathologischer Prozesse Zentralblatte fur Allgeneine Pathologie und Pathologische Anatomie (JENA), 24, 1-9, 1913.
14. Dawker, T.R., Moore, F.E., and Mann, G.V. Coronary heart disease in the Framingham Study. Amer. J. Public Health 47 (Suppl. 4), 4-23, 1957.
15. Albank, M.J. and Mar, E.B. Serum tryglycerides in coronary artery disease. Arch. Int. Med. 103, 4-8, 1959.
16. Jones, H., Gotman, J.W., Lindgren, F., Lyon, T., Graham, D., and Stresower, B. Liproproteins in atherosclerosis. Amer. J. Med. 11, 358-380, 1951.
17. Meyer, J.S., Waltz, A.G., Hess, J.W., and Zak, B. Serum lipid and cholesterol levels in cerebrovascular disease. Arch. Neurol. (Chicago) 1, 303-311, 1959.
18. Schrade W. and Bohle, E. On Hyperlipidemia and atherosclerosis. J. Atheroscler. Res. 2, 161-170, 1962.
19. Berry, J.F., Resch, J.A., and Baker, A.B. Serum lipids and cerebral atherosclerosis in terminal cancer patients. Neurol. (Minneap.) 16, 673-79, 1966.
20. Popova, N.N. Criteria of diagnoses of cerebral atherosclerosis. Abstr. Soviet Med. (Part B) 4, 444, 1960.
21. Baladimas, M.C., Kesley, O.J., and Hurxthal, L.M. Serum cholesterol values and vascular disease. Geriatrics 23, 108-114, 1968.
22. Kannel, W.B., Dawker, T.R., Cohen, M.E., and McNamara, P.M. Vascular disease of the brain — epidemiologic aspects. The Framingham Study. Amer. J. Public Health, 55 (Part 2), 1355-1366, 1965.
23. Nefzger, M.D., Heyman, A., LeBauer, J., Friedberg, S., and Lewis, J. Serum cholesterol levels in myocardial and cerebral infarction caused by atherosclerosis. J. Chron. Dis. 20, 593-602, 1967.
24. Merskey, H., Gillis, A., Attwood, E.C., and Woodford-Williams, E. Serum lipid and lipoprotein variation in atherosclerosis and mental disorder. Gerontol. Clin. 1, 137-147, 1959.
25. Cummings, J.N. and Marshall, J. Serum lipids and cerebrovascular disease. Amer. Heart J. 76, 584-86, 1968.
26. Cummings, J.N., Grundt, I.R., Holland, J.T., and Marshall, J. Serum lipids and cerebrovascular disease. Lancet 2, 194-195, 1967.
27. Molcharov, V.V. Alteration in the circulation of cholesterol and lipoproteins in the serum of patients with disorders of the cerebral circulation. Tr. Sarotovsh Med. Insta 39, 47-56, 1963, cited in Chem. Abstracts 60, 16327c, 1964.
28. Habib, G.B. Neurosyphilis: clinical experience in the diagnosis and treatment. West Ind. Med. J. 11, 100-116, 1962.
29. Millikan, C.H., Siekert, R.G., and Whisnant, J.P. Intermittent carotid and vertebral basilar insufficiency associated with polycythemia. Neurol. (Minneap.) 10, 188-196, 1960.
30. Millikan, C.H. The pathogenesis of transient focal cerebral ischemia. The Lewis A. Conner Memorial Lecture. Circulation 32, 438-450, 1965.
31. Lavy, S. and Herishianu, Y. Polycythmic reaction in the acute ischemic stroke. J. Neurol. Sci. 10, 173-178, 1970.
32. Meyer, J.S., Gilroy, J., Barnhart, M.I., and Johnson, J.F. Therapeutic thrombolysis in cerebral arterial thrombo-embolism. Neurol. (Minneap.) 13, 927-937, 1963.

33. Gilroy, J., Barnhart, M.I., and Meyer, J.S. Treatment of the acute stroke with low molecular weight dextran. Randomized trial with observations concerning platelet function during therapy. J.A.M.A. 210, 293-298, 1969.
34. Hollenhurst, R.W. Significance of bright plaques in the retinal arteries. J.A.M.A. 178, 23-29, 1961.
35. Walsh, R., Barnhart, M. I., Gilroy, J., and Hughes, J. Platelet function in chronic cerebrovascular disease. To be presented at the International Conference of Hematology, Munich, Germany, 1970.
36. Meyer, J.S., Leiderman, H., and Denny-Brown, D. Electroencephalographic study of insufficiency of the basilar and carotid arteries in man. Neurol. (Minneap.) 6, 455-477, 1956.
37. Fisher, C.M. The use of anticoagulants in cerebral thrombrosis. Neurol. (Minneap.) 8, 311-332, 1958.
38. Denny-Brown, D. Recurrent cerebrovascular episodes. Arch. Neurol. (Chicago), 2, 194-210, 1960.
39. Gilroy, J. and Meyer, J.S. Pituitary insufficiency with cerebral vascular symptoms. New Eng. J. Med. 269, 1115-1119, 1963.
40. Sheehan, S., Bauer, R.B., and Meyer, J.S. Vertebral artery compression in cervical spondylosis. Neurol. (Minneap.) 10, 968-986, 1960.
41. Bauer, R.B., Sheehan, S., and Meyer, J.S. Arteriographic study of cerebrovascular disease. II Cerebral symptoms due to kinking, tortuosity and compression of carotid and vertebral arteries in the neck. Arch. Neurol. (Chicago) 4, 119-131, 1961.
42. Harden, C.A., Williamson, W.P., and Steegman, A.T. Vertebral artery insufficiency produced by cervical osteoarthritis spurs. Neurol. (Minneap.) 10, 355-358, 1960.
43. Meyer, J.S., Bauer, R.B., and Wechsler, N. EEG disorders resulting from deficits in circulation of the brain. Medical Records and Annals, Houston, Texas. 54, 334-336, 1961.
44. Bauer, R.B., Wechsler, N., and Meyer, J.S. Carotid compression and rotation of the head in occlusive vertebral artery disease. Ann. Int. Med. 55, 283-291, 1961.
45. Fields, W.S. Clinical evaluation of the stroke process: Productive value of the new diagnostic techniques in *Stroke Rehabilition, Basic Concepts and Research Trends* compiled and edited by Wm. S. Fields and Wm. A. Spencer, St. Louis. Warren H. Green, Inc., 1967, pp 56-67.
46. Fields, W.S., Crawford, E.S., and DeBakey, M.E. Surgical considerations in cerebral arterial insufficiency. Neurol. (Minneap.) 8, 801-808, 1958.
47. Martin, M.J., Whisnant, J.P., and Sayre, G.P. Occlusive vascular disease in the extracranial circulation. Arch. Neurol. (Chicago) 3, 530-538, 1960.
48. Whisnant, J.P., Martin, M.J., and Sayre, G.P. Arteriosclerotic stenosis of cervical arteries. Arch. Neurol. (Chicago) 5, 429-432, 1961.
49. Balla, J.I., Howat, J.M.L., and Walton, J.N. Cholesterol emboli in retinal arteries. J. Neurol. Neurosurg. Psychiat. 27, 144-148, 1964.
50. Calverley, J.R., & Millikan, C.H. Complications of carotid manipulation. Neurol. (Minneap.) 11, 185-189, 1961.
51. Fields, W.S. Surgery for occlusive cerebrovascular disease. Progress report of the Joint Study of Extracranial Arterial Occlusion in *Cerebral Vascular Diseases.* Transactions of the Fifth Conference, Princeton, N.J. Edited by Millikan, C.H., Siekert, R.G., and Whisnant, J.P. New York. Grune and Stratton, 1966, 245-253.
52. Dyll, L.M., Dyll, J.W., and Speer, R.S. Removal of a thrombus attached to a courant needle. Stroke, a journal of cerebral circulation. 1, 104-106, 1970.
53. Barham, Carter A. Hypotensive therapy in stroke survivors. Lancet 1, 485-489, 1970.

From Day 1

The Positive Approach To The Care of the Stroke Patient

By Helen M. Millen, R.N.
Detroit

The catastrophy of a cerebral vascular accident is aptly described by the word stroke. The patient is literally struck down and, with a befuddled brain, half his body paralyzed, often aphasic, he arrives at the hospital frightened, depressed and dependent. Lacking in self-motivation, he faces a bleak future and poor nursing care literally strangles this patient in a mantle of invalidism.

"Poor nursing care." Fighting words to you? Then you are ready to hear Dr. Burtram E. Howard, Coordinator of the Stroke Unit at St. Lukes Hospital in Massachusetts say, "If nurses and doctors were to fight harder, many more stroke patients would return to active, useful lives."

Stroke units or stroke intensive care units are springing up all over the country, but at the present time the bulk of these patients are cared for in regular hospital beds. The challenge for nursing begins at each of these beds. But, can we make these patients recepients of intensive stroke care? Reviewing the work in stroke inten-

---

Miss Millen is a rehabilitation Nursing Consultant with the Kenny-Michigan Rehabilitation Foundation and is on the faculty of the Wayne State University College of Nursing.

sive care units (and here I am not referring to the heroic, life-saving measures that occur in regular Intensive Care Units) we do not find any astonishing new techniques or therapies. Every stroke patient is approached with the attitude that he is going to walk out of the hospital and be a functional member of society. Sound familiar? Of course. This is just the kind of care we are trained to give. The purpose of nursing is to assist the patient to get well, get better, or live within the framework of his limitations or disability. We can do it with stroke.

Like the weather man, we must change our approach to the situation. For years he predicted the weather as partly cloudy. Now he, just as truthfully, states it will be partly sunny. So with the stroke patient. He has half his body paralyzed, but he also has half his body functioning and we will concentrate on the positive.

Following the admission procedures, lab work, lumbar punctures, X-rays, etc., nursing should begin to mobilize the patient. If a sophisticated team — physical therapist, occupational therapist, speech therapist, etc., is available at your hospital, the patient still remains in the nurse's care for 22-23 hours a day. We must prevent disabling deformities. The bed should have a firm mattress with a ¾ inch plywood bed board. Keep the bed as flat as possible. Gatching promotes hip and knee flexion. A small pillow under the head is sufficient.

Proper positioning and passive range-of-motion will prevent the common deformities of external hip rotation, flexion contracture of hip and knee, dropped foot. In the upper extremity, adduction and internal rotation of the shoulder, flexion contracture at the elbow, dropped wrist, and clenched fist.

The upper extremity should be abducted, preferably at right angles to the shoulder, the forearm in external rotation, the wrist in cocked up position, fingers partially extended over a hand roll.

Hips should be kept straight. When supine, the feet should rest firmly against a foot board, heels clear of the mattress. A trochanter roll (bath blanket or small sandbag) will prevent external rotation of the affected hip. One of the best methods for prevention of hip flexion contractures is to place the patient prone. Remember to keep the toes clear of the mattress. How many prone patients have you seen on your wards lately?

The first bath should be therapeutic, as well as cleansing — incorporating range-of-motion. This would be passive flexion, extension, rotation, abduction and adduction. All these activities can be worked easily into bed bathing routines. This passive range-of-motion can prevent deforming, immobilizing contractures.

It can even do more than that. Should the patient indicate by word, facial expression, gesture, or some questions about range-of-motion of the upper extremity, acknowledge this query with the reply, "This may bother you a little, but you will very soon want to bathe and dress yourself. You will need this arm strong and working." Lower extremity range-of-motion questioned by the patient should bring the answer, "We want to keep this leg moving easily so you can stand and walk in a few days."

The professional nurse, regardless of position, has stature with the patient and these words may be the first ray of hope the patient has that he might function normally again. There is no need to wait several weeks to let him know it. **Day one** is the crucial time.

Range-of-motion three to four times a day is a NURSING procedure. We will simply put a group of muscles and the joints through a normal range of activity. Family members will welcome an opportunity to do something for their loved ones, and it might ease our ever-present shortage of help to involve them.

Begin at once to encourage the patient to help with his bath and other bed activities. He can help move about in bed, should learn to turn over, etc.

Bed-fast patients make limited progress in self-care. They should be up as soon as possible. Postural hypotension, frequently given by nurses as a reason for not getting patients up in a chair, has less chance of developing if the patient is up early. We have already proven the value of "out of bed early" with surgical patients.

In the St. Lukes Stroke Unit, this "Up early" is often the DAY OF THE STROKE!! and it includes cardiovascular accidents from hemorrage. Dr. Howard states these patients are less apt to continue bleeding when upright, as blood pressure tends to be lower than when supine. Blood pressure is checked as soon as the patient is up (a cuff is in place) and, if pressure drops, the patient is put back to bed for ten minutes. He is then placed in the chair again. Hypotension seldom occurs the second time. Comatose and semi-comatose patients are helped to remain upright by nursing attendants.

Contrast this revolutionary approach to the average stroke patient who six to 12 weeks after stroke cannot turn over in bed because nursing has not taught him that he can do it.

As the patient progresses, he is assisted from the bed to chair by one trained person. It is possible to handle most stroke patients this way, providing the nurse is physically fit for her job and has a working knowledge of good, safe body mechanics. A well stablized low bed is essential also. Interpret the doctor's order "patient may be up in a chair one hour" realistically. He does not say, "use hoyer lift" or "use two orderlies." These just reinforce the feeling of helplessness. I get them up alone.

In the unit used as a previous example, patients are soon assisted to dress themselves in their own clothing. Most patients would do better if this were allowed in hospitals, but this morale booster for the stroke patient has unmeasured value. He is soon learning to dress himself.

Meals are another activity of daily living that occur several times a day on the nursing unit. The patient is quickly encouraged to help feed himself. As he progresses to meal independence, he may, at first, need two special considerations. A full tray might confuse him so one dish is placed on the tray at a time. With this arrangement he is also less apt to knock things off the tray because of poor coordination. I wonder how often these embarrassing spills discourage further development of eating skills. If the patient has hemianopsia (loss of either right or left half of visual fields in both eyes) food is placed in the line of the unaffected visual field. You can protect the patient's clothing with a large bib and staff should be near to encourage and assist as necessary. Spinning plates can be stabilized with a wet paper towel, or a wash cloth wrung out of water.

Fluids to 2,500 cc. in the waking hours are encouraged. A small glass, a child's training cup, or a moldable plastic cup will help get fluids into those who have difficulty swallowing. Drooling because of this difficulty is common and embarrassing to the patient. Sucking on a lollipop will encourage redevelopment of facial and swallowing muscles.

If the facial nerves are involved, eye problems, such as the loss of the blink reflexes may be present, eyes should be irrigated with drops three times daily. It is a time saver to provide eye care equipment at the bedside with articles for oral hygiene.

Stroke patients lose bladder function, but in a large percentage of patients this is temporary. Catherizing these patients to keep the bed dry is a great disservice. It makes bladder training more difficult and catheters are a primary source of urinary tract infection. There is no way of telling which patient will regain function in three to five days or in a prolonged period. Offer all patients the opportunity to void every two hours for 48-72 hours. If you find you must use a catheter for a time, try to remove it in a week or so. Bowels are less of a problem if training starts early. Put these patients on a toilet or commode after breakfast, or at the patient's usual time of defecation. Ten or fifteen minutes is long enough. Enemas or suppositories should be given, if necessary, at this time.

Decubitus can be prevented by turning the patient at least every two hours and keeping the skin dry. The earlier the patient is out of bed, the less danger of skin and tissue breakdown.

Ambulation can be started by nursing. Encourage early exercises. Isometric muscle setting in bed, activity – moving about in bed and, finally, standing. While assisting the patient to stand, teach him to bend each knee alternately and return to the straight position. A second exercise, while standing, is to balance on each leg for an increasing length of time.

Walking should be encouraged, first in parallel bars, or with two attendants. The patient can progress to a crutch, or walker and finally to a cane. Try to avoid the stiff kneed circumducted gait so commonly found by encouraging the patient to flex the knee and hip, bring the leg forward, dorsiflex the ankle and step down on the heel. Straighten the knee and rock forward on the toe. Try for a smooth rhythm. Only a few patients are totally unable to ambulate. This is not a loss of muscle control, but rather the result of brain damage which limits memory and comprehension or loss of proprioception. Splinting and braces can help weak muscles, but gadgetry will not splint this mental loss. End organs of joints, muscles and skin provide sensory impulses to the brain which gives us the ability to locate and orient our bodies in space. Loss of this proprioception makes motor activity difficult or impossible. The patient with this loss does not know where any part of the body is located unless he is looking at it, or what part of the body is bearing weight, or is in motion. Walking is not a realistic goal for this patient. Teach him to use his able hand for power on the wheel of his chair and his working foot for a rudder so he can travel where he would like to go. This wheelchair activity is best learned by trying it yourself.

Aphasia is frustrating for the patient and the nurse. Loss of language skills for communication may be receptive, expressive, or both. Dr. Harlan will no doubt explain this in depth, but we must learn to communicate with these patients by asking questions that can be answered by yes or no. Do not ask for a choice, the patient will be confused and you will be frustrated. Yes or no, by word, facial expression or gesture can soon be understood by interested staff members who take time to do so. I was asked to provide an aphasic patient for a nursing conference. I found a dapper exsalesman who could say one word, No! The doctor evaluating him for the session thought it might be a very frustrating demonstration. However, the interview proceeded smoothly with the skillful questioning by the physician and, as the patient realized his time on stage was drawing to an end, he informed the audience by that one word "no," gestures and facial expressions that, had he known there would be so many beautiful women present, he would have left his wife home. Not one of the 175 nurses present failed to understand him. Help prevent family frustration by instructing them about the aphasic patient. It will avoid all the shouting and they will not treat the patient as a mentally incompetent child.

Stroke patients need both physical and psychological stimulation to keep functioning at their best capacity. They must not be allowed to sit and wait for paralyzed limbs to "get better." Grouped with other stroke patients with similar difficulties, they work out problems and encourage one another. They are stimulated by the others' success to try a little harder themselves. Meaningful activity to develop skill, strength and coordination should be encouraged. The staff should know one-handed activities, practice rolling over in bed as a hemiplegic, sitting up in bed, dressing, eating and you will better understand the frustration of the patient. Re-learning activities is hard work for them and the nurse can influence the patient's recovery by her attitude and actions. Staff PATIENCE and consistency of instructions are essential for success, and success starts on the first day of recovery.

I recently visited a brilliant school teacher who was a true "stroke victim" – nightgown, robe, felt slippers, no make-up, dull hair-do, being waited on like a child by her peers. When I questioned her desultory existance she cried out, "But I never knew a stroke patient who got better."

There will be failures. We won't win them all, but 90 to 95% of stroke patients are capable of some self-care, dressing, transfers, tub, showers, toileting, feeding, in some combination. A large number can be left alone for a period of time in the day. Eighty-five to ninety percent of stroke patients can ambulate without assistance. I am willing to settle for those figures.

To make them happen, we must not allow these patients or their families to see them as half paralyzed, but rather as a PERSON who has one good arm, and one good leg, and with those two limbs we will teach him to do everything he did before, not quite so fast, not quite so well, but sufficiently well to take care of his own needs – to live – and to enjoy that life.

INFORMATION FOR CONTRIBUTORS

1. Address scientific manuscripts to the Publication Committee, Michigan State Medical Society, 120 West Saginaw Street, East Lansing, Michigan 48823.

2. Submit original, double-spaced typewritten copy and two carbon copies or photo copies on letter size (8½ x 11 inch) paper.

3. On page one, include title, authors, degrees, academic titles, and any institutional or other credits.

4. Authors are responsible for all statements, methods, and conclusions. These may or may not be in harmony with the views of the Editorial Staff. It is hoped that authors may have as wide a latitude as space available and general policy will permit. The Publication Committee expressly reserves the right to alter or reject any manuscript, or any contribution, whether solicited or not.

5. Illustrations should be submitted in the form of glossy prints or original sketches from which reproductions will be made by **Michigan Medicine.**

6. Contributors will be notified as soon as practical if a manuscript is accepted for publication. Unused manuscripts will be returned. Every care will be taken with the submitted material but the Journal will not hold itself responsible for loss or damage to manuscripts.

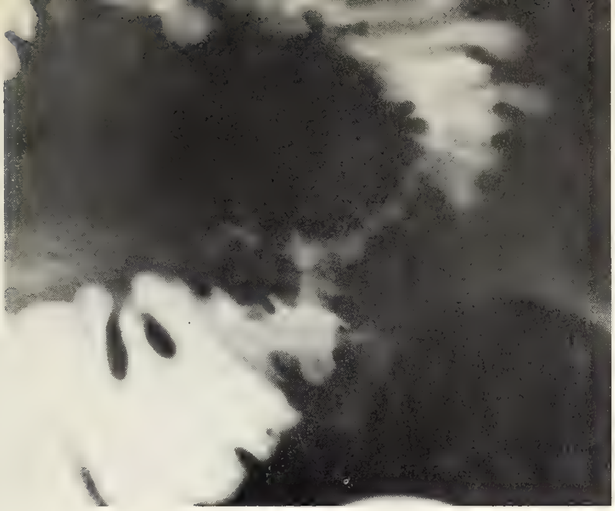
7. Articles should ordinarily be less than four printed pages in length (3000 words).

8. References should conform to *Cumulative Index Medicus,* including, in order: Author, title, journal, volume number, page, and year. Book references should include editors, edition, publisher, and place of publication, as well.

9. Specify address to which galley proofs should be sent. Proofs will be mailed to authors for correction before publication and should be returned to the editor in 48 hours. If proofs approved by the author are not received by the editor prior to deadline, publication of the article will be cancelled for that issue.

10. The editors welcome, and will consider for publication, letters containing information of interest to Michigan physicians, or presenting constructive comment on current controversial issues. News items and notes are welcome.

11. It is understood that material is submitted for exclusive publication in **Michigan Medicine.**



The Viewbox

By Raymond S. Kurtzman, M.D.
Associate Scientific Editor

Diagnosis

Diverticulitus of the Sigmoid Colon.

X-Ray Findings

The colon is narrowed on the barium enema. There is a relatively smooth lesion involving the wall of the sigmoid, representing an intramural abscess, and a small localized tract of barium, representing a walled off perforation, is seen. A few diverticula of the bowel are also visible.

Discussion

Diverticulitis of the colon is often difficult to diagnose and frequently is overdiagnosed radiologically. The barium enema can be completely normal in a patient with diverticulitis, or show only that diverticula are present. The radiologic diagnosis of diverticulitis should be based on evidence of perforation either free or walled off, and abscess either in the wall of the bowel or adjacent to it. Irritability and spasm of the bowel, although they can be present in diverticulitis, are not at all specific. "Spiking" of diverticula and "accordion pleating" are also found at least as often in people without diverticulitis as in those with the disease. Diverticulitis can be differentiated from carcinoma if the mucosa can be demonstrated to be intact. Often, this is impossible and therefore it is frequently difficult to be certain that the patient does not indeed have carcinoma.

Bibliography

Fleischner, F. G.: "Diverticulitus" in Margulis and Burhenne. "Alimentary Tract Roentgenology" C. V. Mosby Co., St. Louis, 1967 pp799.

MICHIGAN
DEPARTMENT
OF PUBLIC
HEALTH

Monthly Surveillance Report

Cases of Certain Diseases Reported
To the Michigan Department of Public Health
For the Five-Week Period Ending July 31, 1970

	1970 This 5-Week Period	1969 Same 5-Week Period	1970 Total To Above Date	1969 Total Same Date	Total Cases for 1969
Rubella	135	255	2520	3595	4307
Congenital Rubella Syndrome	—	—	—	—	—
Measles	320	31	1598	216	401
Whooping Cough	39	13	90	74	192
Diphtheria	—	—	—	—	—
Mumps	300	177	4753	3777	5215
Scarlet Fever & Strep Sore Throat	534	398	7921	6183	9763
Tetanus	0	0	4	2	6
Poliomyelitis (paralytic)	1	—	1	—	—
Hepatitis	466	247	2687	1815	3360
Salmonellosis (other than S. typhi)	81	60	361	287	539
Typhoid Fever (S. typhi)	1	0	7	4	6
Shigellosis	20	21	115	168	300
Aseptic Meningitis	21	10	48	46	179
Encephalitis	25	11	66	59	120
Meningococcic Meningitis	3	7	46	89	114
H. Influenza Meningitis	3	7	36	34	56
Tuberculosis	184	189	1214	1333	2108
Syphilis	345	388	2248	2595	4021
Gonorrhea	1905	1713	11753	10280	19194

Information can be supplied by the local health department on the local incidence of disease.

Maurice Reizen, M.D., Director
Michigan Department of Public Health

Perinatal Tips

By Paul M. Zavell, M.D.
Detroit

The following case from the files of the Wayne County Medical Society Perinatal Mortality Committee is presented as an aid in continuing education.

Maternal

This was the fourth pregnancy for this 27 year old A+ white mother. Her first two pregnancies ended in spontaneous abortions at two and three months gestation respectively. Her third pregnancy resulted in a 1 lb. 6 oz. female infant that lived only three hours. After spontaneous rupture of membranes at 34 weeks of gestation she delivered twin boys. There was but one placenta. Her post-partum course was uneventful.

Fetal

Baby A weighed 4 lbs. 3¾ oz. with an apgar of 9 at 1 minute. He was plethoric but no other findings or problems were noted.

Baby B weighed 3 lbs. with an apgar of 7 at 1 minute. He was pale, did not breathe spontaneously and required resuscitation. Because he was having difficulty while Baby A was not, he was transferred quickly by the nursing staff to the nursery for immediate care by the pediatrician while Baby A remained with the obstetrician who attended the mother. Baby B in the nursery required endotracheal resuscitation but expired in one hour despite heroic methods to combat the respiratory problem. Baby A's hemoglobin shortly after birth was 30.2 mgm % so that he required a phlebotomy. By 48 hours of age his hemoglobin was 22.2 gm % and Hematocrit was 76%. He was badly jaundiced with a bilirubin of 20.8 mgm % so that an exchange transfusion was done. His course thereafter was uneventful and seven months later he shows normal growth and development.

Perinatal Committee Comments

1. Fetal to fetal transfusions should always be considered in twins if one twin is pale and the other plethoric or quite red at birth.
2. If such a situation repeated itself, both infants might survive through emergency direct infant to infant transfusion, if there is not enough time for usual type, Cross Match and Blood transfusion.
3. The present case points out clearly the importance and necessity for good communication to exist at all times between the obstetrician and the pediatrician as well as the nursing staff.

Doctor Zavell is chairman, Neo-Natal and Hospital Care Committee, Michigan Chapter, A.A.P., and chairman, Perinatal Mortality Study Committee, Wayne County Medical Society.

MICHIGAN
DEPARTMENT
OF PUBLIC
HEALTH

Monthly Surveillance Report
Cases of Certain Diseases Reported To The Michigan Department of Public Health For The Four-Week Period Ending August 28, 1970

	1970 This 4-Week Period	1969 Same 4-Week Period	1970 Total To Above Date	1969 Total Same Date	Total Cases for 1969
Rubella	101	141	2621	3736	4307
Congenital Rubella Syndrome	—	—	—	—	—
Measles	84	42	1682	258	401
Whooping Cough	32	13	122	87	192
Diphtheria	—	—	—	—	—
Mumps	152	127	4905	3904	5215
Scarlet Fever & Strep Sore Throat	268	270	8189	6453	9763
Tetanus	0	1	4	3	6
Poliomyelitis (paralytic)	0	0	1	0	0
Hepatitis	352	237	3039	2052	3360
Salmonellosis (other than S.typhi)	71	72	432	359	539
Typhoid Fever (S.typhi)	1	0	8	4	6
Shigellosis	19	16	134	184	300
Aseptic Meningitis	52	25	100	71	179
Encephalitis	21	15	87	74	120
Meningococcic Meningitis	3	3	49	92	114
H. Influenza Meningitis	1	7	37	41	56
Tuberculosis	170	165	1383	1495	2108
Syphilis	285	261	2533	2856	4021
Gonorrhea	1812	1736	13565	12016	19194

Information can be supplied by the local health department on the local incidence of disease.

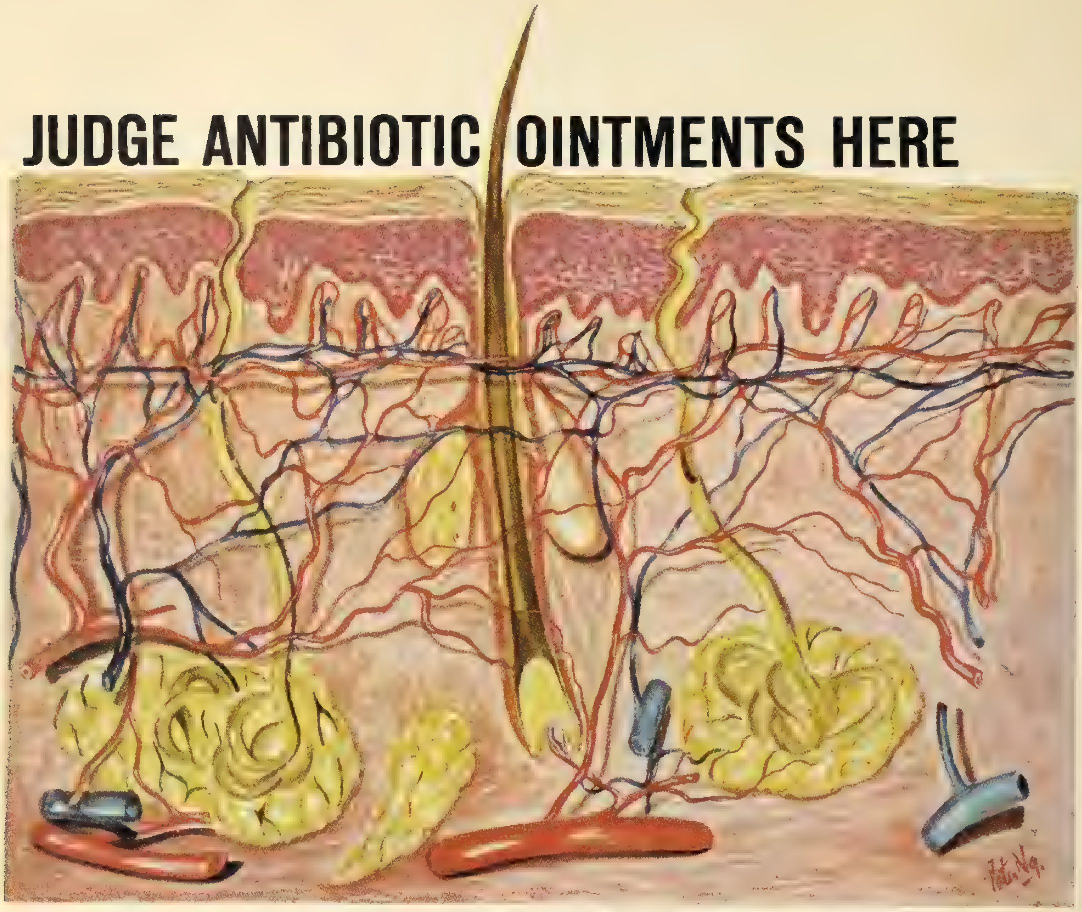
CALORIES / 7 oz. Serving*

Beef Broth	22	Vegetable	68
Consommé	29	Tomato	69
Chicken with Rice	43	Cream of Asparagus	70
Chicken Gumbo	48	Cream of Chicken	76
Chicken Noodle	54	Cream of Mushroom	115
Cream of Potato	58	Green Pea	116
Chicken Vegetable	60	Cream of Shrimp (Frozen)	132
Vegetable Beef	66	Bean with Bacon	133

In planning high or low calorie diets, Campbell's more than 50 different soups offer you a wide choice. And, most of Campbell's Soups contain a wide variety of ingredients that can serve as supplementary sources of many essential nutrients.

* From "Nutritive Composition of Campbell's Products" which gives values of important nutritive constituents of all Campbell's Products. For your copy, write to Campbell Soup Company, Dept. 536, Camden, New Jersey 08101.

There's a soup
for almost every patient and diet
..for every meal
and, it's made by Campbell



JUDGE ANTIBIOTIC OINTMENTS HERE

Results on skin are final proof of any topical antibiotic's effectiveness

No in vitro test can duplicate a clinical situation on living skin. 'Neosporin' (polymyxin B —bacitracin—neomycin) Ointment has consistently proven its effectiveness in thousands of cases of bacterial skin infection. The spectra of the three antibiotics overlap in such a way as to provide bactericidal action against most pathogenic bacteria likely to be found topically. Diffusion of the antibiotics from the special petrolatum base is rapid since they are insoluble in the petrolatum, but readily soluble in tissue fluids. The Ointment is bland and nonirritating.

Caution: As with other antibiotic preparations, prolonged use may result in overgrowth of nonsusceptible organisms and/or fungi. Appropriate measures should be taken if this occurs. Articles in the current medical literature indicate an increase in the prevalence of persons allergic to neomycin. The possibility of such a reaction should be borne in mind.
Contraindications: This product is contraindicated in those individuals who have shown hypersensitivity to any of its components.
Supplied: Tubes of 1 oz., ½ oz. with applicator tip, and ⅛ oz. with ophthalmic tip.
Complete literature available on request from Professional Services Dept. PML.

'NEOSPORIN'®
brand
POLYMYXIN B-BACITRACIN-NEOMYCIN
OINTMENT

BURROUGHS WELLCOME & CO. (U.S.A.) INC., Tuckahoe, N.Y.

The girth control pill

Tepanil® Ten-tab®

(continuous release form)

(diethylpropion hydrochloride)

works on the appetite not on the 'nerves'

When girth gets out of control, TEPANIL can provide sound support for the weight control program you recommend. TEPANIL reduces the appetite—patients enjoy food but eat less. Weight loss is significant—gradual—yet there is a relatively low incidence of CNS stimulation.

Contraindications: Concurrently with MAO inhibitors, in patients hypersensitive to this drug; in emotionally unstable patients susceptible to drug abuse.

Warning: Although generally safer than the amphetamines, use with great caution in patients with severe hypertension or severe cardiovascular disease. Do not use during first trimester of pregnancy unless potential benefits outweigh potential risks.

Adverse Reactions: Rarely severe enough to require discontinuation of therapy, unpleasant symptoms with diethylpropion hydrochloride have been reported to occur in relatively low incidence. As is characteristic of sympathomimetic agents, it may occasionally cause *CNS effects* such as insomnia, nervousness, dizziness, anxiety, and jitteriness. In contrast, CNS depression has been reported. In a few epileptics an increase in convulsive episodes has been reported. Sympathomimetic *cardiovascular effects* reported include ones such as tachycardia, precordial pain, arrhythmia, palpitation, and increased blood pressure. One published report described T-wave changes in the ECG of a healthy young male after ingestion of diethylpropion hydrochloride; this was an isolated experience, which has not been reported by others. *Allergic phenomena* reported include such conditions as rash, urticaria, ecchymosis, and erythema. *Gastrointestinal effects* such as diarrhea, constipation, nausea, vomiting, and abdominal discomfort have been reported. Specific reports on the hematopoietic system include two each of bone marrow depression, agranulocytosis, and leukopenia. A variety of miscellaneous adverse reactions have been reported by physicians. These include complaints such as dry mouth, headache, dyspnea, menstrual upset, hair loss, muscle pain, decreased libido, dysuria, and polyuria.

Convenience of two dosage forms: TEPANIL Ten-tab tablets: One 75 mg. tablet daily, swallowed whole, in midmorning (10 a.m.); TEPANIL: One 25 mg. tablet three times daily, one hour before meals. If desired, an additional tablet may be given in midevening to overcome night hunger. Use in children under 12 years of age is not recommended.

T-006A / 1/70 / U.S. PATENT NO. 3,001,910

THE NATIONAL DRUG COMPANY
DIVISION OF RICHARDSON-MERRELL INC.
PHILADELPHIA, PENNSYLVANIA 19144

Painful night leg cramps...

unwelcome bedfellow for any patient— including those with arthritis, diabetes or PVD

One thing patients can sleep without, particularly patients with chronic disease conditions such as arthritis, diabetes or PVD, is painful night leg cramps. Although seldom the presenting complaint, night leg cramps can tie your patients up in painful knots. Now, just one tablet of QUINAMM at bedtime can usually bring an end to shattered sleep and needless suffering. Your patients will sleep restfully—gratefully—with QUINAMM, specific therapy to prevent painful night leg cramps.

Prescribing Information—Composition: Each white, beveled, compressed tablet contains: Quinine sulfate, 260 mg., Aminophylline, 195 mg. **Indications:** For the prevention and treatment of nocturnal and recumbency leg muscle cramps, including those associated with arthritis, diabetes, varicose veins, thrombophlebitis, arteriosclerosis and static foot deformities. **Contraindications:** QUINAMM is contraindicated in pregnancy because of its quinine content. **Precautions/Adverse Reactions:** Aminophylline may produce intestinal cramps in some instances, and quinine may produce symptoms of cinchonism, such as tinnitus, dizziness, and gastrointestinal disturbance. Discontinue use if ringing in the ears, deafness, skin rash, or visual disturbances occur. **Dosage:** One tablet upon retiring. Where necessary, dosage may be increased to one tablet following the evening meal and one tablet upon retiring. **Supplied:** Bottles of 100 and 500 tablets.

THE NATIONAL DRUG COMPANY
DIVISION OF RICHARDSON-MERRELL INC.
PHILADELPHIA, PENNSYLVANIA 19144

Quinamm™ Specific therapy for night leg cramps
(quinine sulfate 260 mg., aminophylline 195 mg.)

Q915A

If the law prescribes that dangerous and addicting drugs shall not be sold surely this law can be enforced in a restricted area regardless of the effort required or the number of long hairs that may be soiled.

If venereal disease is a concern of public health departments then surely pro stations can be established in the same way as they are provided for servicemen in areas of high exposure. Not for their value in the control of disease, but rather as a tacit reminder that all libertines who attend such functions are not free of infection.

Somewhere in this world there may be a place for a rock festival. Until they are organized on the same high plane as the Jazz Festival in Newport, or the Shakespearean Festival in Stratford, they have little to commend them. Many parents have refused their children attendence at rock festivals as they are now conducted. They deserve recognition for their perception. It really appears that any rock music provided is incidental. One can recall that only recently a large contingent of our youth remained on a mountain in Connecticut for some days despite the fact that the performers had been eliminated by court order.

If youth is to be served in its desire for good music all well and good. It is the responsibility of all of us to see that "festival" does not become the hippy term for "orgy."

Should Medical Schools Play Central Part?

In this issue of *Michigan Medicine,* the topic of the "your opinion please" feature on these pages is the medical profession's role in relation to the currently popular rock festivals.

Thus, the question originally announced for the October issue, has been postponed to be highlighted in the November issue. That subject is "Suggest one way that you feel county medical societies could change their operations to become more relevant to the needs, problems and opportunities of their members."

In December, the topic of discussion will be:

"Do you believe the medical schools should assume the central role not only in the education of physicians but also in determining the nature and quality of health care services provided to the community?"

We invite Michigan physicians' responses to all three topics. The articles submitted for the December issue must be in our office by Nov. 1.

Edward J. Lynn, M.D.
East Lansing

For centuries the physician has engaged with others in the mutual deception that he is expert in many areas outside of medicine. There is no medical school curriculum, internship or residency that prepares a physician to render expert opinion on whether or not rock festivals should be held. What gives one pleasure is a private decision and it is our legal, not medical, system which should allow its expression and at the same time provide for safeguards for the rights of others.

Pharmacological recreation is a part of the human condition. The paradox that some drugs are sanctioned and their use encouraged while similar acting agents are illegal and their use harshly punished contributes to the "drug problem."

Our drug taking orientation gets started early when as children we learn that if we are up, down or sideways there is some medicine that can make us feel better. Our parental models for drug taking along with the constant drug bombardment by the communications media reinforce this orientation. Other contributions are the over-producing pharmaceutical firms and harried physicians who in league with desperate patients have created the myth that anxiety or depression should not be tolerated for more than several milliseconds. Add to this the present political-social-economic milieu and the background for the drug using behavior among our youth becomes more clear.

Young people have learned that drugs are among many of the things that give them pleasure. It is not surprising, then, that rock festivals and drugs might go hand in hand. I have been impressed, however, both as a physician in attendance at a rock festival and by the accounts of others, by the peaceful, pleasurable gatherings of huge crowds of youngsters. More peaceful, I might add, than many of the high school football games I attended in my youth, where drugs were not an issue.

As physicians we do have a legitimate role in terms of the possible dangers that drug taking may lead to. We need to provide honest, accurate and complete data about drugs to the public. Telling adolescents what to do or what not to do is a blind alley. Accepting them as thinking and feeling human beings who can make appropriate decisions when faced with sufficient information is the route which usually proves most fruitful. In addition, trained medical and paraprofessional staff should be available (as they should for any large gathering) to handle trauma, the occasional birth and the not-as-common-as-expected drug reaction that may present at rock festivals.

(Continued on Page 901)

BREAKUP—symbol of the impact of emotional stress. But when the stress exceeds transient rage or depression—and settles into a chronic mixed anxiety depression state—combined tranquilizer-antidepressant therapy could be indicated.

FOR MODERATE TO SEVERE ANXIETY WITH COEXISTING DEPRESSION

TRIAVIL®

TRANQUILIZER-ANTIDEPRESSANT

Containing perphenazine and amitriptyline HCl

For prescribing information, including indications, contraindications, warnings, precautions, and side effects, please see following page.

FOR MODERATE TO SEVERE ANXIETY WITH COEXISTING DEPRESSION

TRIAVIL®

TRANQUILIZER-ANTIDEPRESSANT

Containing perphenazine and amitriptyline HCl

TRIAVIL®2-10: Each tablet contains 2 mg. of perphenazine and 10 mg. of amitriptyline hydrochloride.

TRIAVIL®2-25: Each tablet contains 2 mg. of perphenazine and 25 mg. of amitriptyline hydrochloride.

TRIAVIL®4-10: Each tablet contains 4 mg. of perphenazine and 10 mg. of amitriptyline hydrochloride.

TRIAVIL®4-25: Each tablet contains 4 mg. of perphenazine and 25 mg. of amitriptyline hydrochloride.

INDICATIONS: Patients with moderate to severe anxiety and/or agitation and depressed mood; patients with depression in whom anxiety and/or agitation are severe; patients with depression and anxiety in association with chronic physical disease; schizophrenics with associated depressive symptoms.

CONTRAINDICATIONS: Central nervous system depression from drugs (barbiturates, alcohol, narcotics, analgesics, antihistamines); bone marrow depression; pregnancy; and in patients with known hypersensitivity to phenothiazines or amitriptyline. Do not give in combination with MAOI drugs because of possible potentiation that may even cause death. Allow at least two weeks between therapies. In such patients therapy with TRIAVIL should be initiated cautiously, with gradual increase in the dosage required to obtain a satisfactory response. Do not give concomitantly with guanethidine or similarly acting compounds since it may block the antihypertensive effect.

WARNINGS: Patients should be warned against driving a car or operating machinery or apparatus requiring alert attention, and that response to alcohol may be increased.

PRECAUTIONS: Suicide is always a possibility in mental depression and may remain until significant remission occurs. Supervise patients closely in case they may require hospitalization or concomitant electroshock therapy. Untoward reactions have been reported after the combined use of antidepressant agents having various modes of activity. Accordingly, consider possibility of potentiation in combined use of antidepressants. Use with caution in patients with glaucoma and those with problems of urinary retention. Perphenazine can lower the convulsive threshold in susceptible individuals. It should be given with caution to patients with convulsive disorders. Dosage of the anticonvulsive agent may have to be increased. Not recommended for use in children. Mania or hypomania may be precipitated in manic-depressives (perphenazine in TRIAVIL seems to reduce likelihood of this effect). If hypotension develops, epinephrine should not be employed, as its action is blocked and partially reversed by perphenazine. Caution patients about errors of judgment due to change in mood.

ADVERSE REACTIONS: Similar to those reported with either constituent alone.

Perphenazine: Should not be used indiscriminately. Use caution in patients who have previously exhibited severe reactions to other phenothiazines. Likelihood of untoward actions greater with high doses. Closely supervise with any dosage. Side effects may be any of those reported with phenothiazine drugs: extrapyramidal symptoms (opisthotonos, oculogyric crisis, hyperreflexia, dystonia, akathisia, dyskinesia, parkinsonism) usually controlled by the concomitant use of effective antiparkinsonian drugs and/or by reduction in dosage, but sometimes persist after discontinuation of the phenothiazine; skin disorders (photosensitivity, itching, erythema, urticaria, eczema, up to exfoliative dermatitis); other allergic reactions (asthma, laryngeal edema, angioneurotic edema, anaphylactoid reactions); peripheral edema; reversed epinephrine effect; hyperglycemia; endocrine disturbances (lactation, galactorrhea, disturbances of menstrual cycle); altered cerebrospinal fluid proteins; paradoxical excitement; EKG abnormalities (quinidine-like effect); reactivation of psychotic processes; catatonic-like states; autonomic reactions, such as dryness of the mouth, headache, nausea, vomiting, constipation, obstipation, urinary frequency, blurred vision, nasal congestion, and a change in the pulse rate; hypnotic effects; pigmentary retinopathy; corneal and lenticular pigmentation; occasional lassitude; muscle weakness; mild insomnia. Other adverse reactions reported with various phenothiazine compounds, but not with perphenazine, include blood dyscrasias (pancytopenia, thrombocytopenic purpura, leukopenia, agranulocytosis, eosinophilia); liver damage (jaundice, biliary stasis); grand mal convulsions; cerebral edema; polyphagia; photophobia; skin pigmentation; and failure of ejaculation. Significant unexplained rise in body temperature may suggest intolerance to perphenazine, in which case discontinue. Antiemetic effect may obscure signs of toxicity due to overdosage of other drugs or make diagnosis of other disorders such as brain tumors or intestinal obstruction difficult. May potentiate the action of central nervous system depressants (opiates, analgesics, antihistamines, barbiturates, alcohol) and atropine. In concurrent therapy with any of these, TRIAVIL should be given in reduced dosage. May also potentiate the action of heat and phosphorous insecticides.

Amitriptyline: Careful observation of all patients recommended. Side effects include drowsiness (may occur within the first few days of therapy); dizziness; nausea; excitement; hypertension; fainting; fine tremor; jitteriness; weakness; headache; heartburn; anorexia; increased perspiration; incoordination; impotence; increased appetite and weight gain; allergic-type reactions manifested by skin rash, swelling of face and tongue, itching; numbness and tingling of limbs, including peripheral neuropathy; activation of latent schizophrenia (however, the perphenazine content may prevent this reaction in some cases); epileptiform seizures; temporary confusion, disturbed concentration, or transient visual hallucinations on high doses; evidence of anticholinergic activity, such as tachycardia, dryness of mouth, stomatitis, blurring of vision, reversible dilatation of the urinary tract, urinary retention, constipation, paralytic ileus; agranulocytosis; jaundice. Elderly patients and adolescents can often be managed on lower dosage levels.

For more detailed information, consult your MSD Representative or see the package circular. Merck Sharp & Dohme, Division of Merck & Co., Inc., West Point, Pa. 19486.

MSD MERCK SHARP & DOHME

I feel that any other comments or attitudes I have about rock festivals should be expressed elsewhere as a concerned citizen and parent and not as a physician.

(Doctor Lynn is an assistant professor in the Department of Psychiatry at Michigan State University. He is also a consultant to the Governor's Office on Drug Abuse and to the Drug Information Project at MSU.)

The following four articles are in response to the question asked for the September "your opinion please" feature in the September Journal. The question was "what suggestions would you make to best insure fullest delivery of services to all persons requiring mental health care, in view of the increasing complexity and confusion that exists in the delivery of mental health care services?"

Sister Mary Janice Belen
Lansing

The burden of the delivery of mental health care services has seemingly fallen to the newly established comprehensive community mental health centers. This situation has resulted from governmental fiat or decree, which smacks of magical thinking. Assuming that a Congressional Act can somehow bring about the solution to a problem that has been beyond our reach for decades, let us try to look at the mandate given to community mental health, namely, to service people from all walks of life who live within a circumscribed geographical area.

The emergence of a new mental health care delivery system has produced the concept of the catchment area. In some sense it is basic to the delivery system, for it more than implies that agencies can no longer close their doors to clients but *must* provide services. This situation might indeed result in a new orientation towards helping people. No longer can administrators and professionals answer this dilemma by hiring more staff — the coffers are rapidly becoming depleted.

The demand for services by clients must be met by a sophisticated organizational structure which provides coordinated services leading to optimum continuity of care. Mental health care to all that require it, means that we must utilize our professional staffs more effectively and in increasingly more innovative ways and at the same time decrease daily client treatment costs.

Community mental health centers must reach out, not only to make themselves visible to the community so that people can more effectively seek help, but to provide consultation to those institutions and non-mental health professionals who can supply the needed manpower and assistance in expanding the delivery system.

The outreach must attempt to integrate the work of the private mental health practitioners with the effort of the public sector. Most importantly, professionals are no longer free to independently determine the mental health needs of the community. They must also be committed to seeking solutions to mental health problems through input from consumers, possibly in the form of citizen advisory boards.

Those of us who have somehow been "magically" selected to carry out the mandate of community mental health, indeed, have a yeoman's task in the years ahead.

(Sister Mary Janice Belen is administrator of St. Lawrence Hospital, Lansing.)

Roger W. Howell, M.D.
Ann Arbor

One of the most pressing problems which I see in the Mental Health field today is that Mental Health Professionals have not seen themselves as a very central part of government, whether it be state or local, or of the community. Most of the help which we can give must involve Welfare, Education or Public Health (within which I include Mental Health.) The Law Enforcement Agencies and the Clergy also seem to be resources through which we could be reaching troubled persons although I recognize that the Clergy are not a part of Government.

There are a large number of helping people in this State who are not a part of government. They do deal with troubled people most of their time. Among these are ambulance drivers and attendants, pharmacists, undertakers and Special Education people, just to name a few.

Communication between these groups, as well as with government, seems very poor, and yet these are the agencies and institutions which must deal with troubled people and their families.

Only some state level financing will make this communication possible.

(Doctor Howell is associate professor of community mental health in the School of Public Health, The University of Michigan.)

Jose J. Llinas, M.D.
Lansing

Clinical psychiatric services are used by about 1% of the population in most areas of the country. Careful surveys show that the number of severely disabled people is at least 3% of the population. In especially high risk groups (school children,

(Continued on Page 904)

His makeup is unique by tradition.

His ulcer treatment is unique by tradition, too.

In the world of entertainment, a clown's makeup remains the exclusive property of its originator. Time has established that tradition. In the treatment of ulcers and other gastrointestinal complaints, time has established Pro-Banthine as a tradition too.

Few drugs can boast a longer successful run. Introduced 17 years ago, this drug is a veteran gastrointestinal performer.

Pro-Banthine stars in the treatment of peptic ulcer, functional gastrointestinal disturbances, ulcerative colitis, hypertrophic gastritis, pylorospasm, acute and chronic pancreatitis, diverticulitis, biliary dyskinesia, hyperhidrosis, ileostomies, and colonic, ureteral or urinary bladder spasm. Its fame as an anticholinergic is worldwide.

When you want a performer you can count on . . . remember Pro-Banthine. Tradition does.

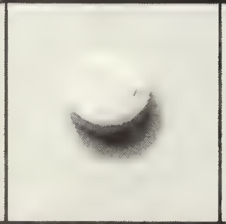
SEARLE Research in the service of medicine.
G. D. Searle & Co., Chicago, Ill. 60680

Pro·Banthine®

(propantheline bromide)

the traditional ulcer treatment

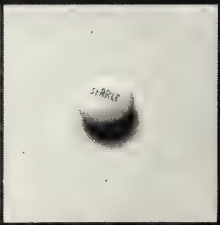
Pro-Banthine 15 mg.
propantheline bromide



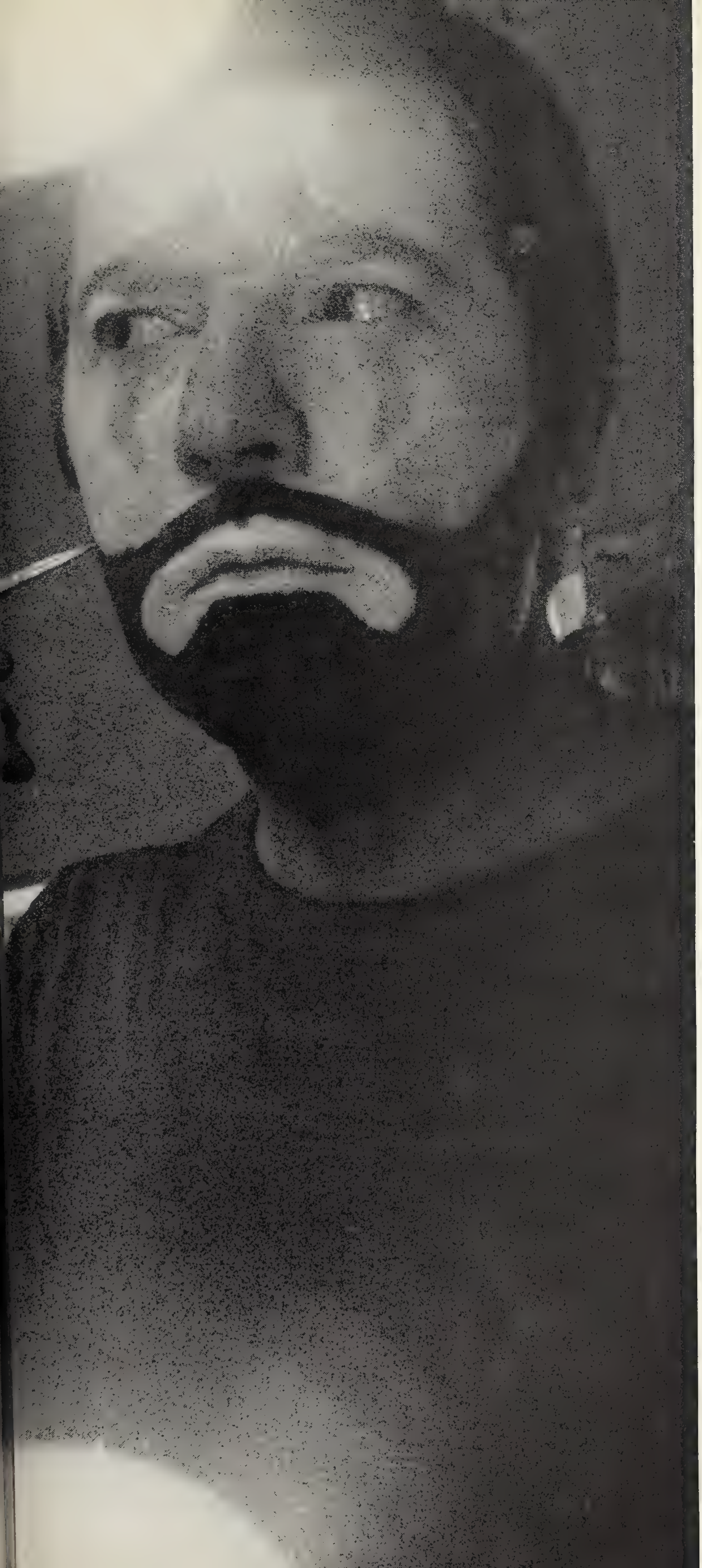
Pro-Banthine 15 mg.
propantheline bromide
with
Dartal 5 mg.
thiopropazate
dihydrochloride

Pro-Banthine 15 mg.
propantheline bromide
with
Phenobarbital 15 mg.
warning:
may be habit forming

Pro-Banthine P.A. 30 mg.
propantheline bromide
in time-release form



Pro-Banthine 7½ mg.
propantheline bromide
Half Strength



Pro·Banthīne®
(propantheline bromide)

Indications: Peptic ulcer, gastroenteritis, pylorospasm, biliary dyskinesia, functional hypermotility and irritable colon.

Contraindications: Glaucoma, severe cardiac disease.

Precautions: Since varying degrees of urinary hesitancy may occur in elderly men with prostatic hypertrophy, this should be watched for in such patients until they have gained some experience with the drug. Although never reported, theoretically a curare-like action may occur with possible loss of voluntary muscle control. Such patients should receive prompt and continuing artificial respiration until the drug effect has been exhausted.

Side Effects: The more common side effects, in order of incidence, are xerostomia, mydriasis, hesitancy of urination and gastric fullness.

Dosage: The maximal tolerated dosage is usually the most effective. For most adult patients this will be four to six 15-mg. tablets daily in divided doses. In severe conditions as many as two tablets four to six times daily may be required. Pro-Banthīne is supplied as tablets of 15 mg., as prolonged-acting tablets of 30 mg. and, for parenteral use, as serum-type vials of 30 mg. The parenteral dose should be adjusted to the patient's requirement and may be up to 30 mg. or more every six hours, intramuscularly or intravenously.

Pro·Banthīne® 15 mg.
(propantheline bromide)
with
Dartal® 5 mg.
(thiopropazate dihydrochloride)

Indications: Peptic ulcer, spastic constipation, nonspecific gastritis, functional gastrointestinal disorders, pylorospasm, hyperhidrosis, irritable bowel syndrome, mucous or ulcerative colitis, functional diarrhea.

Contraindications: Glaucoma, severe cardiac disease.

Warnings: Pro-Banthīne with Dartal should not be administered to patients who are under the influence of barbiturates, alcohol or narcotics. The drug should be administered cautiously to epileptic patients or those in depressed states, patients with liver disease and to pregnant women. Hypersensitivity to Dartal may occur rarely in patients with known sensitivity to similar drugs.

Side Effects: Dryness of the mouth, mydriasis, hesitancy of urination; less commonly extrapyramidal (restlessness, dystonia and signs of pseudoparkinsonism such as muscular rigidity, fixed facies, tremor, ataxia, festinant gait and drooling), parasympatholytic (blurred vision, xerostomia, hypotension, nasal congestion and constipation) and curare-like (loss of control of voluntary muscles, particularly the muscles of respiration) reactions. Rarely, leukopenia or allergic purpura. A generalized erythematous skin reaction may occur. Side effects characteristic of phenothiazines such as grand mal convulsions, altered cerebrospinal proteins, cerebral edema, potentiation of the effects of atropine, heat or phosphorus insecticides, autonomic reactions, endocrine disturbances, reversed epinephrine effect, hyperpyrexia or pigmentary retinopathy may theoretically occur but have not been reported with Dartal. Severe hypotension following recommended doses occurs more commonly in patients who are also afflicted by other medical disorders such as mitral insufficiency or pheochromocytoma, and particular attention should be paid to such a possibility although this has not been observed with Dartal.

Adult Dosage: One tablet three times a day.

Pro·Banthīne® 15 mg.
(propantheline bromide)
with
Phenobarbital 15 mg.

Warning: May be habit-forming.

For *Indications, Contraindications, Precautions, Side Effects* and *Dosage* see Pro-Banthīne. In addition, phenobarbital should be administered with caution to patients with liver disease, mental disturbances or a significant degree of hypoxia.

Pro·Banthine P.A.®
prolonged acting brand of propantheline bromide

For *Indications, Contraindications, Precautions* and *Side Effects* see Pro-Banthīne.

Dosage Form: Capsule-shaped, compression-coated, peach tablets of 30 mg. for oral use.

Dosage: The recommended initial dosage is one tablet in the morning and one at night.

084

SEARLE

Research in the service of medicine.
G. D. Searle & Co., Chicago, Ill. 60680

adolescents, the economically deprived) it is probably closer to 10% or more at any particular time.

True, more resources than ever before are becoming available at federal, state and local levels.

The gap between the needs for service, and the services truly available to people, is still abysmal.

Shall we throw our hands up in despair?

Or shall we, optimistically, but with a realistic awareness of the enormity of the problem, keep trying?

In the state of Michigan we have made some beginnings. If we want them to blossom into full-fledged solutions we should:

1. Continue to support services at the community level and under community control.

2. Encourage public and private services to work cooperatively, side by side — the need is large enough that *both* will always be needed.

3. Keep Psychiatry in the mainstream of medicine.

4. Continue to train and encourage general and family physicians to carry a share of the load.

Example: In developing psychiatric services in the small town of Charlotte, in central Michigan, no qualified psychiatrist was available. When the problem was explained to the Eaton County Medical Society, three general practitioners in the tiny community volunteered their services for a psychotropic "Medication Clinic." It has been in operation for two years now, with gratifying success!

5. State mental health operations should be strongly decentralized. Let the local communities do it for themselves!

In the long run, the services will be more financially stable, more productive, and more appropriate to the local needs.

(Doctor Llinas is mental health director for the combined Clinton, Eaton and Ingham counties, with offices in Lansing.)

Benjamin Jeffries, M.D.
Harper Woods

The observation that the delivery of care to the mentally ill is increasingly complex and confusing depends upon which delivery system you are observing.

Currently, there is a delivery system in the public sector financed by tax dollars and a delivery system in the private sector financed by private dollars.

The complexity and attendant confusion in the delivery of Mental Health Care is mainly a phenomenon of the public sector. This is the result of the fragmentation of services provided by government, both horizontally and vertically. The complexity is increased by built-in rigidities necessitated by government statute and organization. This is equally true at all levels of government.

At the local level in the metropolitan areas, we see the independent programming of services, which again have rigid eligibility rules which are sometimes made even more complicated by differing interpretation of function and sphere of operation. Thus, we observe patients who are the responsibility of the State Department of Mental Health refused care by city and county resources.

Admission into the service network of the public sector may be quite complex depending upon residency requirements and government agency rules on admission and referral which usually have to be formally documented which adds time and rigidity to the system.

In contrast, the private sector has a coordinated, continuity of care system which is readily accessible and simple to enter. The system is as near and accessible as the family physician. This is a coherent system which is internally integrated and coordinated by the medical societies and hospital associations at the local as well as the national level.

At this time, government is in a dilemma as to which course to follow. Should we continue the traditional fragmented system now extant or should we attempt to emulate the physician based system of the private sector which revolves around the patient-physician relationship?

Medicare and Medicaid have been attempts in the latter direction. These plans have resulted in better quality care for a significant number of individuals dependent on government resources. The major criticism has been expense which was predicted but denied and rationalized by program planners.

I think it is essential that there be more realistic pooling and utilization of resources in both the public and private sectors. This will depend principally upon government's ability to trust the elements in the private sector, appreciate their problems and for government to modify its rigidity.

The insurance of delivery of Mental Health Care to all of those requiring it is an ideal which is limited by the priorities for all health care and services. These are determined by the constrictions of finance and manpower and not peculiar to Mental Health Care, comprehensive Medical Care or conservation of the environment.

(Doctor Jeffries is chairman of the MSMS Committee on Mental Health.)

The actions of the official
Tincture and Extract of
Belladonna result chiefly from
their Atropine content . . .
conclude Goodman and Gilman

THE PHARMACOLOGICAL BASIS OF THERAPEUTICS
3rd Edition, page 522

ANTROCOL®

Antrocol provides the prompt, predictable antisecretory action of the belladonna alkaloid, atropine, fortified with sedation and blended with Bensulfoid, contributing to even absorption.

Each tablet or capsule contains: Atropine sulfate, 0.324 mg.; Phenobarbital, 16 mg. (may be habit forming); Bensulfoid, 65 mg. (see white section PDR). The atropine content of Antrocol is the maximum amount the average patient can take at six hour intervals over long periods with comfort.

SUPPLIED
Tablet in bottles of
100, 500 and 5000
Capsule in bottles
of 100, 500 and 1000

Caution: Federal law prohibits dispensing without prescription.

PRESCRIBING INFORMATION

Contraindicated in glaucoma. Use cautiously in prostatic hypertrophy. Side-effects of toxic dose of atropine: flushing, dryness of mouth, cycloplegia, tachycardia and urinary retention.

DOSAGE: One tablet or capsule after each meal to correct emotional stress and normalize gastric secretions. In treating peptic ulcer, doses at regular intervals up to eight (8) tablets or capsules per day to provide the proper gastric titer for healing. After ulcer has healed, one tablet or capsule after each meal to maintain a titer unfavorable to recurrence.

Clinical supply available to physicians.

WILLIAM P. POYTHRESS & CO., INC.
RICHMOND, VIRGINIA 23217
Manufacturers of Ethical Pharmaceuticals

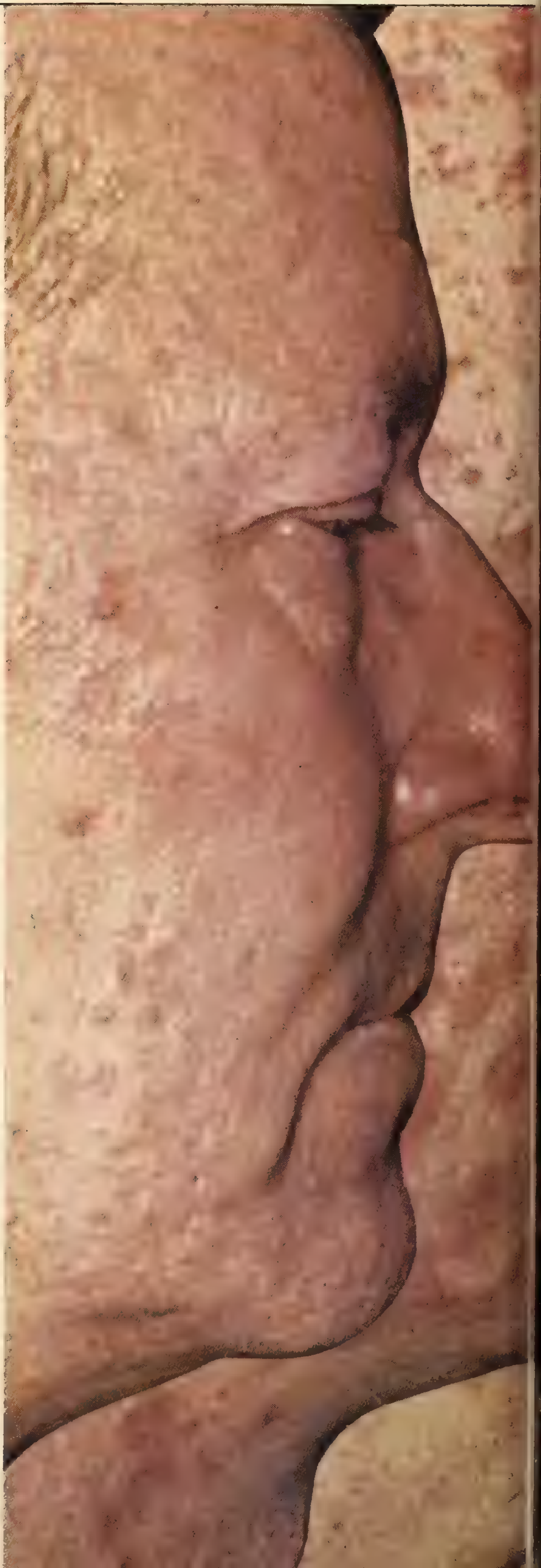
Roche
announces

Efudex®

(fluorouracil)
cream/solution

for the treatment of solar/actinic keratoses... a topical alternative to conventional therapy

1/22/68—Treatment with 5% 5-FU cream commences. Patient K.L. showing widespread but mild solar keratoses (also known as actinic keratoses).



Fluorouracil—the Roche contribution

In 1962, Roche Laboratories introduced Fluorouracil Roche® (5-fluorouracil). Early clinical work with this drug suggested that it possessed a selective cytotoxic activity when applied topically to certain kinds of lesions. Based on this work and years of clinical trials, a standardized form of topical fluorouracil can now be recommended for treatment of multiple solar or actinic keratoses.

Efudex® (fluorouracil)—a new alternative to conventional therapy

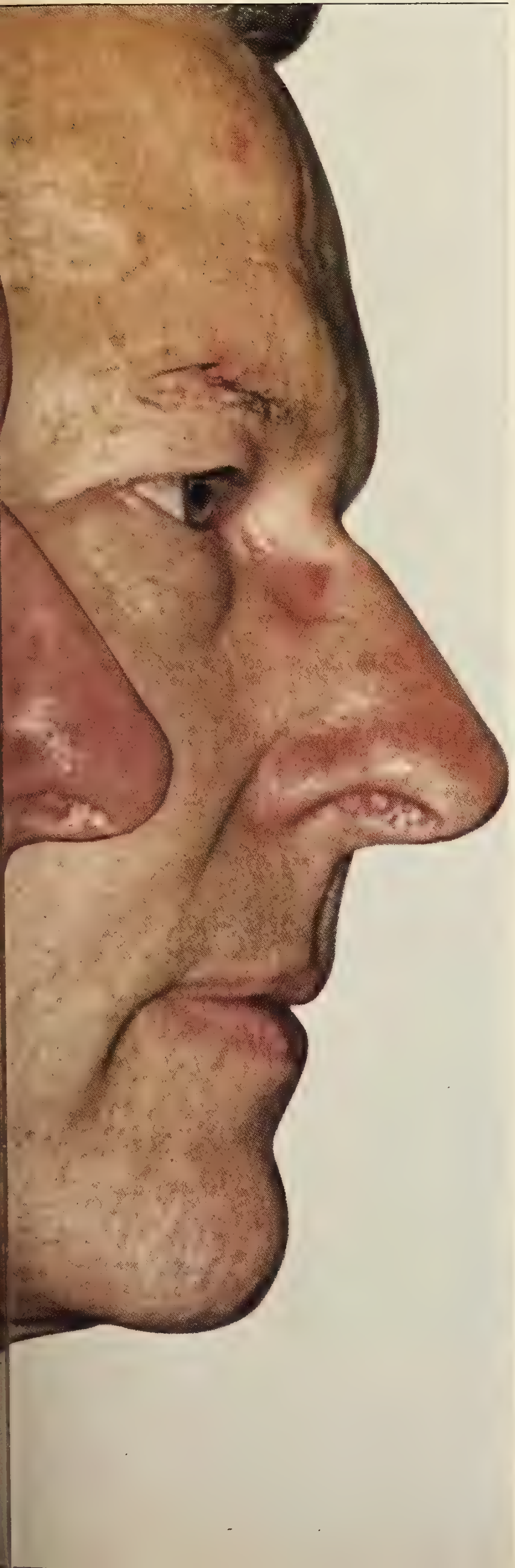
Efudex presents the physician with a topical alternative to surgery in the treatment of solar or actinic keratoses. It is effective, comparatively inexpensive and especially well-suited for treatment of multiple lesions. Important, too, is the highly desirable cosmetic result. Clinical experience demonstrates that treatment with Efudex results in an extremely low incidence of scarring.*

Highly effective on first and later applications

In clinical trials, depending on the dosage form and strength used, complete involution occurred in 77 to 88 per cent of lesions following treatment. The rate of recurrence was low, ranging from 1.7 to 5.6 per cent up to a year after completion of therapy. When lesions did recur or new ones appeared, repeated courses of Efudex therapy proved effective.*

2/68—After 11 days of treatment. ythema is seen at site of keratoses. In ldition, numerous lesions not apparent ior to therapy have become manifest sharply defined reactions. Intervening in, also treated, shows no response to erapy.

'19/69—One year after cessation of erapy. Skin appears clear with no evi- ence of scarring. Examination reveals ck of recurrence or the formation of ew lesions.



Predictable sequence of therapeutic response

Two to four weeks constitutes a typical course of Efudex therapy. The response is usually characteristic and predictable. After three or four days of treatment, erythema begins to appear in the area of the keratoses. This is followed by an intense inflammatory response, scaling and occasionally moderate tenderness or pain. The height of the inflammatory reaction generally occurs two weeks after the start of therapy, and then begins to subside as treatment is stopped. Within two weeks of discontinuing medication, the inflammation is usually gone. A mild erythema may remain for two to three months before gradually receding.

Selective—with a high degree of safety

Despite the temporary unsightliness and discomfort of the inflammatory episode, Efudex is, in general, more readily tolerated than surgery. Clinical work shows the intense inflammatory response to be limited to the area of the lesion. Normal skin is not similarly affected. Another measure of Efudex safety: systemic absorption of topical fluorouracil was insignificant, indicating a low risk of systemic toxicity.*

Two strengths—two convenient dosage forms

Efudex is available as a 2% or 5% solution or as a 5% cream. It is applied twice daily by the patient with a nonmetal applicator or suitable glove.

Before prescribing Efudex, however, there are two important considerations. First, please consult the complete prescribing information for precautions, warnings and adverse reactions. Second, advise the patient that treated lesions should respond with the characteristic but transient inflammation. A positive sign that Efudex is working for them.

*Data on file, Hoffmann-La Roche Inc., Nutley, New Jersey.

2% and 5% Solutions; 5% Cream Applied twice daily—resolves solar or actinic keratoses.

new
Efudex®
(fluorouracil)
cream/solution

For full prescribing information, please see the following page.

Roche introduces

Efudex®

(fluorouracil) cream/solution the new standardized topical for solar/actinic keratoses

Description: Efudex solutions and cream are topical preparations containing the fluorinated pyrimidine 5-fluorouracil, an antineoplastic antimetabolite.

Efudex Solution consists of 2% or 5% fluorouracil on a weight/weight basis, compounded with propylene glycol, tris-(hydroxymethyl) aminomethane, hydroxypropyl cellulose, parabens (methyl and propyl) and disodium edetate.

Efudex Cream contains 5% fluorouracil in a vanishing cream base consisting of white petrolatum, stearyl alcohol, propylene glycol, polysorbate 60 and parabens (methyl and propyl).

Actions: There is evidence that the metabolism of fluorouracil in the anabolic pathway blocks the methylation reaction of deoxyuridylic acid to thymidylic acid. In this fashion fluorouracil interferes with the synthesis of deoxyribonucleic acid (DNA) and to a lesser extent inhibits the formation of ribonucleic acid (RNA). Since DNA and RNA are essential for cell division and growth, the effect of fluorouracil may be to create a thymine deficiency which provokes unbalanced growth and death of the cell. The effects of DNA and RNA deprivation are most marked on those cells which grow more rapidly and which take up fluorouracil at a more rapid pace. The catabolic metabolism of fluorouracil results in degradative products (*e.g.*, CO_2, urea, α-fluoro-β-alanine) which are inactive.

Studies in man with topical application of ^{14}C-labeled Efudex demonstrated insignificant absorption as measured by ^{14}C content of plasma, urine and respiratory CO_2.

Indications: Efudex is recommended for the topical treatment of multiple actinic or solar keratoses.

Contraindications: Efudex is contraindicated in patients with known hypersensitivity to any of its components.

Warnings: If an occlusive dressing is used, there may be an increase in the incidence of inflammatory reactions in the adjacent normal skin.

Prolonged exposure to ultraviolet rays should be avoided while under treatment with Efudex because the intensity of the reaction may be increased.

Usage in Pregnancy: Safety for use in pregnancy has not been established.

Precautions: If Efudex is applied with the fingers, the hands should be washed immediately afterward. Efudex should be applied with care near the eyes, nose and mouth. To rule out the presence of a frank neoplasm, a biopsy should be made of those areas failing to respond to treatment or recurring after treatment.

Adverse Reactions: The most frequently encountered local reactions were pain, pruritus, hyperpigmentation and burning at the site of application. Other local reactions included dermatitis, scarring, soreness and tenderness.

Also reported were insomnia, stomatitis, suppuration, scaling, swelling, irritability, medicinal taste, photosensitivity and lacrimation.

Laboratory abnormalities reported were leukocytosis, thrombocytopenia, toxic granulation and eosinophilia.

Dosage and Administration: Efudex should be applied twice daily with a nonmetal applicator or suitable glove in an amount of the solution or cream sufficient to cover the lesion. When Efudex is applied to a lesion, a response occurs with the following sequence erythema, usually followed by vesiculation, erosion, ulceration, necrosis and epithelization. The lower frequency and intensity of activity in adjacent normal skin indicate a selective cytotoxic property. Medication should be continued until the inflammatory reaction reaches the erosion, necrosis and ulceration stage, at which time use of the drug should be terminated. The usual duration of therapy is from 2 to 4 weeks. Complete healing of the lesion may not be evident for 1 to 2 months following cessation of Efudex therapy.

How Supplied: Efudex Solution, 10-ml drop dispensers—containin 2% or 5% fluorouracil on a weight/weight basis, compounded with propylene glycol, tris(hydroxymethyl)aminomethane, hydroxypropyl cellulose, parabens (methyl and propyl) and disodium edetate.

Efudex Cream, 25-Gm tubes—containing 5% fluorouracil in a vanishing cream base consisting of white petrolatum, stearyl alcohol, propylene glycol, polysorbate 60 and parabens (methyl and propyl).

Clinical Studies: The effectiveness of the three preparations as determined by complete involution of solar keratoses was: 2% Solution, 77% of 282 lesions; 5% Solution, 88% of 202 lesions; and 5% Cream, 85% of 189 lesions. In those lesions where complete involution followed treatment, the rate of possible recurrences observed clinically at periods up to 12 months or more was: 2% Solution, 4.6% of 218 lesions; 5% Solution, 1.7% of 177 lesions; and 5% Cream, 5.6% of 160 lesions. Because of the toxic potential of fluorouracil, some physicians preferred to use the 2% solution when large areas were to be treated. Approximately 30% of the lesions required treatment for two weeks or less; approximately 78% required four weeks or less for adequate treatment.

ROCHE
Roche
LABORATORIES
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

In dermatologic disorders...

the advantages of ALLERSONE OINTMENT in dermatologic disorders

antiinflammatory
■
antipruritic
■
antiallergic
■
anesthetic

IN THE MANAGEMENT of common dermatologic disorders, ALLERSONE provides more than symptomatic relief for your frustrated patient. Because ALLERSONE combines the antiinflammatory, antiallergic and antipruritic action of hydrocortisone with the anesthetic effect of diperodon HCl, it can make a worthwhile contribution to your therapeutic regimen.

ALLERSONE has long provided safe, effective and economical therapy for the anxious patient plagued by dermatologic problems. In addition, it is greaseless, odorless, colorless, as well as washable; thereby assuring a high degree of cosmetic acceptance.

ALLERSONE
OINTMENT

for effective topical management

COMPOSITION: Representing: Hydrocortisone 0.5%; Diperodon Hydrochloride 0.5%; Calamine 2.5%; Zinc Oxide 2.5% in a water-washable base containing sodium lauryl sulfate, propylene glycol, cetyl alcohol, white petrolatum, methylparaben and propylparaben as preservatives and water.

INDICATIONS: Antiinflammatory, antipruritic, and antiallergic preparation with local anesthetic for use in the treatment of atopic dermatitis, dermatitis venenata or contact dermatitis as ivy or oak poisoning, pruritis ani and vulvae (anogenital pruritus), certain allergic skin diseases as infantile eczema, also chronic eczematoid otitis externa, neurodermatitides, intertrigo, as chafing of opposing skin surfaces as on thighs, axilla and below breasts.

ACTION: Hydrocortisone exhibits marked antiinflammatory activity when applied topically to the skin. It is ameliorative in pruritic, allergic and atopic skin lesions. Diperodon hydrochloride is a surface anesthetic, while the calamine and zinc oxide powders are well-known for their mild astringent and protective actions. The remaining ingredients comprise the water-washable base.

DOSAGE AND ADMINISTRATION: Distribute a small amount by gentle application over affected area, two or three times a day; frequency of application to be reduced with improvement.

CONTRAINDICATIONS: Do not apply in the presence of herpes simplex of the eye, chickenpox or other viral diseases or skin tuberculosis; in the presence of a coexisting bacterial infection, an antibacterial agent should be used concurrently.

PRECAUTIONS: In rare instances local sensitivity reactions might occur. The safety of the use of topical steroid preparations during pregnancy has not been fully established. Therefore, they should not be used extensively on pregnant patients, in large amounts or for prolonged periods of time.

ADVANTAGES: Contains a local anesthetic which quickly ameliorates pain —while hydrocortisone reduces inflammation—in a water-washable vehicle —no desquamation from fats.

CAUTION: Federal law prohibits dispensing without prescription.

HOW SUPPLIED: 0.90 Allersone, pink ointment, available in 15 Gm. tubes and in pound jars.

MALLARD, INC.
PHARMACEUTICAL MANUFACTURERS
DETROIT, MICHIGAN 48216

Michigan Medicine Articles Reprinted In Other Publications

Articles which first appear in *Michigan Medicine* frequently find their way into other publications at the request of interested physicians and authors.

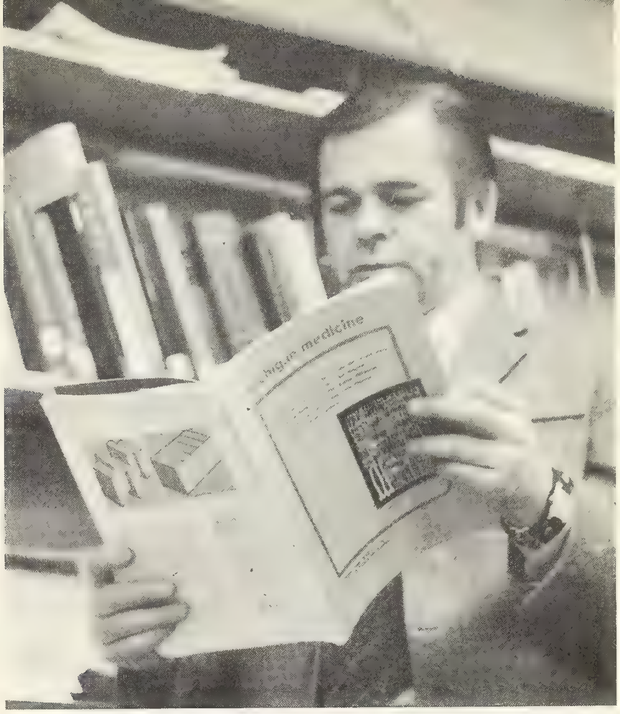
The editors of *International Surgery Bulletin,* making the first comprehensive study, to their knowledge, of malpractice laws around the world, wrote asking permission to incorporate part of a recent *Michigan Medicine* article in their study. The article is "Suggests Ways to Stop Nuisance Malpractice Claims," by John G. Slevin, M.D., from the April, 1969 journal.

Joel I. Hamburger, M.D., Southfield, asked permission to republish in a textbook the substance of three of his own articles first appearing in *Michigan Medicine.* They are "Experience with Thyroid Malignancy in a Private Referral Laboratory," from the June, 1969 issue; "Problems Resulting from Suppressible and Nonsuppressible Thyroid Function," from the January, 1970 issue, and "Spectrum of Autonomous Function in Thyroid Nodules," in the January, 1968 issue.

The Iowa Medical Society recently asked for and received permission to reprint the entire summary by John W. Moses, M.D., Detroit, of the Himler and Budd Reports presented at the AMA's Clinical Convention in December. The Iowa reprints were sent to county medical societies in the state.

Photographic Highlights . . .

of the 1970 MSMS Annual Session Sept. 20-24 in Detroit will appear in the November issue of *Michigan Medicine,* along with important scientific articles and the first in the series of special articles on the University of Michigan study of the postgraduate medical education needs of Michigan physicians.



AMONG THE JOURNALS on display in the reading rooms of the AMA library in Chicago is **Michigan Medicine.** The March, 1970, issue is scanned by the gentleman above.

MSMS Film Well Received By Hospital Employees

"We showed the fine film 16 times to a total of 251 employees," writes a Protestant chaplain thanking MSMS for loaning him the AMA film, "The One Who Heals."

The film, produced by the AMA Department of Medicine and Religion, is available from MSMS for county medical societies, hospitals and other groups.

C. Ronald Phelps, Protestant chaplain at the Allen Park Veterans Administration Hospital, showed the film to help indoctrinate hospital employees and especially nurses. "The film was well received," the chaplain reports.

Lansing Has Third Family Practice Center In Michigan

A Family Practice Center, designed to provide more preventative medicine for the entire family, has been established at E. W. Sparrow Hospital, Lansing.

The hospital also has initiated a Family Practice Residency Program, the third in Michigan. Two others are in operation in Saginaw and Midland and another is under development in Detroit.

CONSTIPATION
EVACUATE GENTLY

With EVAC-U-GEN — your patients with functional constipation can evacuate gently. Because EVAC-U-GEN has a mild laxative action and tends to cause the stool to be soft — it is highly desirable for those sensitive to harsh laxatives — particularly children, pregnant women, and geriatric patients. Recommend EVAC-U-GEN for the management of functional constipation. It is highly effective. Non-griping. Chewable. Very palatable. Economical.

EVAC-U-GEN®

A highly-flavored and palatable tablet of yellow phenolphthalein, bismuth subcarbonate, bismuth subgallate in special base. Chewable. Bottles of 35 and 100. Adult Dose: Chew 1 or 2 tablets night or morning. Children (up to age 10): 1/2 tablet. A citrus drink taken with tablet will stimulate action.
PRECAUTION: Do not use when symptoms of appendicitis are present and discontinue use if skin rash appears. Dependence on laxatives can result from continued use.

W-C PRECISION PHARMACEUTICALS

SEND FOR SAMPLES.
WALKER, CORP & CO., INC.
Syracuse, New York 13201

Michigan Authors

Eduardo L. Reyes, M.D., and Robert W. Talley, M.D., Detroit, "Primary Malignant Tumors of the Small Intestine," page 30, *The American Journal of Gastroenterology,* July, 1970.

Andrew D. Hunt, Jr., M.D., East Lansing, "Institution-Wide Accreditation and Corporate Responsibility," page 602, *Journal of the American Medical Association,* July 27, 1970.

I. J. Schatz, M.D., Detroit, "Unruptured Abdominal Aortic Aneurysms," page 629, *Journal of the American Medical Association,* July 27, 1970.

William S. Jones, M.D., Menominee, "I'm Not Ready to Retire Yet — And I'm 80," page 102, *Medical Economics,* Aug. 3, 1970.

J. W. Hess, M.D., Detroit, and Morton Levitt, Ph.D., formerly of Detroit, now of the University of California at Davis, "New Philosophies in Medical Education," page 1009, *Journal of the American Medical Association,* Aug. 10, 1970.

K. R. Magee, M.D., Ann Arbor, *"Studies in Neurology,"* a book review, page 1041, *Journal of the American Medical Association,* Aug. 10, 1970.

J. I. Hamburger, M.D., Southfield, "Onycholysis in Thyroid Disease," page 1195, *Journal of the American Medical Association,* Aug. 17, 1970.

E. A. Rodin, M.D., E. F. Domino, M.D., J. P. Porzak, Detroit, "The Marihuana Induced 'Social High,'" page 1300, *Journal of the American Medical Association,* Aug. 24, 1970.

Three Michigan Doctors Hold AMA Positions

Three Michigan doctors are currently serving on AMA Councils for 1970-71, and two others are secretaries for AMA Sections, according to recent lists published in JAMA.

Harold F. Falls, M.D., Ann Arbor, is a member of the AMA Council on Health Manpower; George W. Slagle, M.D., Battle Creek, is a member of the Council on Medical Service, and Otto K. Engelke, M.D., Ann Arbor, the Council on Environmental and Public Health.

Serving as secretaries for AMA sections are E. Richard Harrell, Jr., M.D., Section on Dermatology, and George H. Koepke, M.D., Ann Arbor, Section on Physical Medicine and Rehabilitation.

Michigan Mediscene

Oct. 5-9—53rd Annual Meeting, American Dietetic Association, Detroit
Oct. 5-19—MSMS Orient Adventure
Oct. 9—Michigan Association for Regional Medical Programs Annual Meeting, MSMS Headquarters, 1 p.m.
Oct. 11—Michigan Society of Internal Medicine, MSMS Headquarters, 11 a.m.
Oct. 16-17—Michigan State Association of Industrial Nurses Fall Conference, Holiday Inn, St. Joseph
Oct. 18-24—1970 Michigan Community Health Week
Oct. 21-22—Workshop, Michigan TB and Respiratory Disease Association, Michigan Thoracic Society and Michigan Conference of TB Association Workers, Northland Inn, Southfield
Oct. 22—MSMS Workshop on Population Control, sponsored by Lay Education Subcommittee of MSMS Committee on Maternal and Perinatal Health, MSMS Headquarters

Nov. 4—Special meeting of The Council, MSMS Headquarters, noon
Nov. 11—Michigan Cancer Coordinating Committee, MSMS Headquarters, Noon
Nov. 18—MSMS Board of Managers
Nov. 22—Board meeting, Michigan State Medical Assistants Society, MSMS Headquarters, 11 a.m.
Nov. 29-Dec. 2—Many Michigan physicians will participate in the annual AMA Clinical Convention in Boston

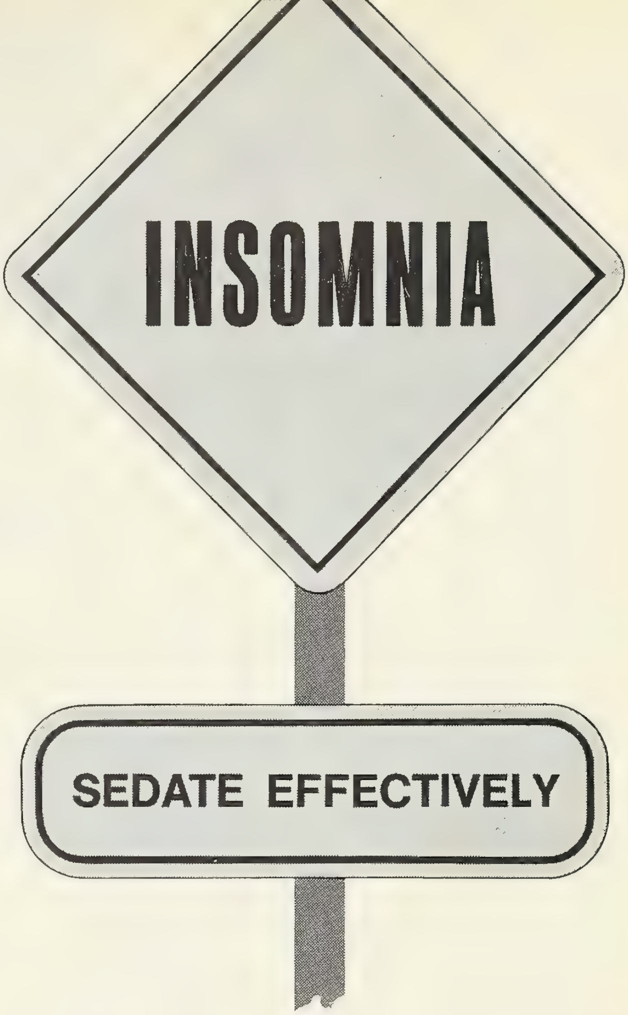
Dec. 2-3—18th Annual Trauma Day, Wayne County Medical Headquarters, Detroit
Dec. 9—MSMS Council, MSMS Headquarters, 9:30 a.m.
Dec. 9—10th Annual Wayne State University Thyroid Workshop, Wayne County Medical Society Auditorium, Detroit

Jan. 30-31—Annual Winter Educational Seminar, Michigan State Medical Assistants Society, The Ramada Inn, Saginaw

April 30-May 2—Annual Meeting, Michigan State Medical Assistants Society, Weber's Motor Inn, Ann Arbor

Lester Dodd Appointed To Campaign Practices Group

Lester P. Dodd, Detroit, MSMS general counsel and former legal counsel, has been appointed to the reactivated Michigan Fair Campaign Practices Commission. Mr. Dodd was first appointed in 1964 by then-Gov. George Romney to the commission, which is active in election years.



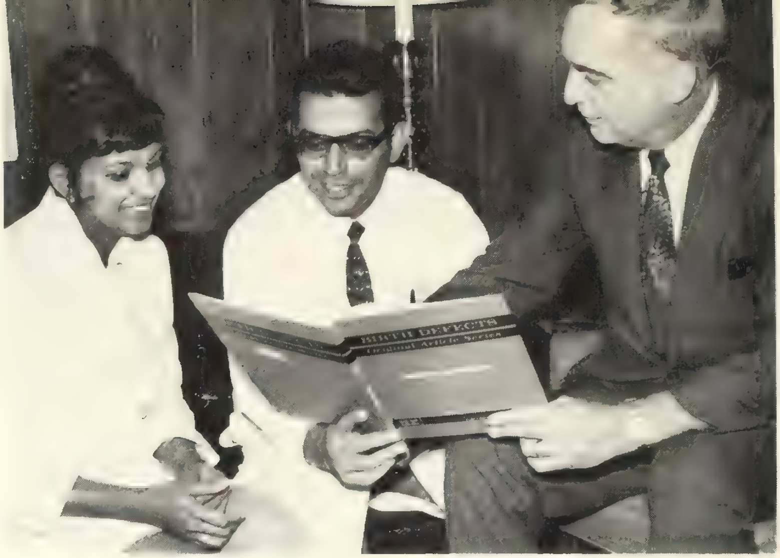
With QUĪ-A-ZONE – you can sedate effectively. A balanced combination of short, intermediate, and long-acting barbiturates (totaling 100 mg.) in a rapidly disintegrating tablet – sedation is provided within a few minutes . . . followed by sound restful sleep . . . usually without morning hangover. The four barbiturates in QUĪ-A-ZONE have dual channels of elimination (renal and hepatic) to lessen metabolic burden, decrease barbiturate retention, and minimize depression.

QUĪ-A-ZONE™

Each rapidly-disintegrating tablet contains 25 mg. secobarbital, 25 mg. pentobarbital, 25 mg. butabarbital, and 25 mg. phenobarbital. Bottles of 100.
Usual Adult Dose: 1 to 2 tablets before retiring.
PRECAUTION: Should not be administered to patients sensitive to barbiturates, or in cases of known previous addiction. Warning: May be habit forming.

W-C PRECISION PHARMACEUTICALS

SEND FOR SAMPLES.
WALKER, CORP & CO., INC.
Syracuse, New York 13201



The new Michigan doctors, Rama Sekharan, M.D., left, and N. C. Sekharan, M.D., center, chat with Darrell E. Statzer, M.D., acting chairman of the Department of Obstetrics-Gynecology at Wayne State University. Both Rama and N. C. Sekharan have done their residency work in the department and will take up new practices in Benton Harbor in January.

Michigan Health Council Passes Milestone In Doctor Placement Program

Benton Harbor soon will have the 999th and 1,000th doctor placed in Michigan by the Michigan Health Council since 1953.

N. C. Sekharan, M.D., and his wife, Rama, of India, are completing residencies in ob-gyn in Detroit, and will start practice Jan. 1 in Benton Harbor.

This story goes back to 1965 when John A. Doherty, MHC executive director, was asked by James Dehlin, M.D., of Gladstone, if he would try to find a hospital in Michigan that would take two young physicians from India who wanted to come to the United States and obtain additional medical education and training.

Doctor Dehlin, who was serving then on the MSMS Council, became acquainted with the young couple through a family friend who learned of the desire of Doctor Sekharan and his wife to come to the United States for more medical education.

Mr. Doherty convinced Robert Wilson, M.D., of the Wayne State University School of Medicine and Detroit General Hospital, that the Sekharans were exceptional young foreign doctors, and Doctor Wilson agreed to review their applications and interview the young couple.

The Sekharans had graduated from Darbhanga Medical College, Bihar (he) and Madras Medical College, Madras (she), at the top of their medical college classes, had passed the foreign medical college examinations with excellent marks, and spoke English fluently because they had attended an English speaking high school in India. Doctor Wilson offered Doctor N. C. Sekharan a residency program in general surgery, and Doctor Rama Sekharan was offered a residency program in obstetrics-gynecology by Tommy Evans, M.D., at Hutzel Hospital. They moved to Detroit with a small son in January of 1967.

Doctor N. C. Sekharan later decided to change his residency training to obstetrics-gynecology and both he and his wife worked and studied at Hutzel Hospital under Doctor Evans, now acting dean at WSU. Doctor Rama Sekharan completed her training early this summer and has just given birth to a daughter. Her husband will complete his residency the end of 1970, and they will move to Benton Harbor to start practice on January 1, 1971.

The young doctors found the opportunity to go to Benton Harbor in the Michigan Health Council Placement Roster and talked to Clinton Wilson, M.D., of Mercy Hospital in Benton Harbor and others. Arrangements were made by Doctor Wilson and the Twin City Emergency Room Physicians Corporation to help the Sekharans find suitable office space and to become affiliated with the emergency room group as a way of becoming established in Benton Harbor. The young family is most appreciative of the help offered by Doctor Wilson, the hospital administration and the medical society in the Twin Cities.

The Michigan Health Council, a voluntary health organization made up of over 100 voluntary and official health and educational organizations, conducts the Placement Program under the guidance of the Michigan State Medical Society. A few days ago the Council received a check for $9,000 from The Upjohn Company of Kalamazoo to assist it in conducting the placement program. Since 1953 The Upjohn Company has contributed nearly $150,000 toward the physician and dentist placement programs operated by the Michigan Health Council. The service is offered free of charge to the community and the doctor.

medical care
programs

'Technocrats'—
A New Professional Breed

By Herbert Mehler, Staff Assistant
MSMS Committee on
Governmental-Medical Care Programs

The dictionary defines technocracy as government by technical experts.

A technocrat in the health field, therefore, is a "highly educated man who can bring finely honed professional skills to the solution of a complex and essentially technical problem — the delivery, with equality, of a high level of care to more than 200 million people." These individuals are categorized as systems analysts, economists, statisticians, social planners, and administrators largely from the professions of engineering, legal, business administration or economic fields.

In this month's journal, the MSMS Committee on Governmental Medical Care Programs is deviating from its usual straight reporting of rules, regulations and standards of governmentally-sponsored programs.

The committee was impressed with an article appearing in *Medical World News* of July 31, 1970 entitled, "Is Health Planning Too Vital to be Left to MDs?" and therefore presents the following excerpts from the article.

> "Right now, the physician is in somewhat the position the military people were, in 1961 when technocrats — the so-called Whiz Kids — took over the Defense Department. It was decided that war was too important to be left to the generals. Likewise, physicians may be the experts in caring for patients, but they cannot be the ultimate decision-makers."
> — Adam Yarmolinsky, Harvard Law Professor and member of the National Academy of Sciences Board on Medicine.

> We are coming to recognize that there has to be a great deal more in-depth planning for the distribution of health care manpower, and that this doesn't necessarily require medical knowledge."
> — HEW Deputy Under Secretary
> Frederic V. Malek

> "One of the first things that has to happen is that doctors recognize that a change is occurring. There has to be a greater communication between the medical profession and the federal government."
> — HEW Deputy Under Secretary
> Frederic V. Malek

> "The profession has been slow to recognize and respond to the new social demands being placed upon it. The result, predictably, has been to weaken the voice of organized medicine in matters of public policy affecting its profession. Economists and social welfare planners, actuaries, labor union spokesmen, and even lawyers have frequently played a larger role than doctors themselves in the shaping of public programs in the medical field."
> — HEW Secretary Elliot L. Richardson

> "I cannot help feeling that a major reason doctors have not had greater influence on such matters is that they have usually not had enough educational background in the economic and social aspects of medical care to be able to grapple with this kind of issue."
> — HEW Secretary Elliot L. Richardson

> "I don't know the degree of formal training required, but if the physician wants to be one of the molders of policy, he is going to have to be equipped to do so. There are all kinds of tools as well as models he is going to have to understand."
> — Rashi Fein, Ph.D.

> "The era of the private doctor . . . cloistered in his private office . . . lobbying through traditional institutions out of step with the times, will be over. Doctors will have to become involved to a greater extent in governmental decision-making. If you refuse, your punishment will be to live under the judgment of less knowledgeable men than yourselves."
> — HEW Under Secretary Veneman

MAILBAG

Time to Reappraise Physicians' Accomplishments, Says Doctor Doolittle

To the Editor,

As a concerned member of the M.M.S., I offer the following retrospective overview, issued as an individual and in no way intended to reflect official opinions of the local medical society (of which I am secretary).

I am very concerned that we are unable to communicate with the public, with industry, with our legislative leaders, and even with our paramedical allies in some instances. During the past decade, we have seen and heard hundreds of statements and "battle plans" against Medicare, which was overwhelmingly passed; we have seen and heard similar statements against the ineptitudes of the state's largest insurance carrier — "The Blues" — yet that company continues on its bungling way, wasting funds and keeping all parties concerned in a state of turmoil; we hear intelligent, cogent reasons for passing an abortion bill and our legislative representatives, perhaps marching to the tune of a better drummer, pay no heed, and stall against passage of one of the most critically needed legislative parcels.

It is time that we reappraise our efforts and our accomplishments. I doubt if any other body of such highly educated reputedly intelligent professionals could match our record of so many thousands of wasted hours with *so little accomplished.* The wastage stems from hundreds of "routine business" meetings, committee meetings, and the time, personnel and material required to document all this busy work.

Let's face facts. The only good listeners are our patients, our social friends, and business associates. John Q. Public, and most importantly the legislators turn deaf ears to us. If we are to continue as something other than a highly organized discussion group, we should turn our efforts to creative projects, regardless of how picayune they might seem to some.

I would like to see:

1. Expansion of all public education services. There should be no shortage of films, booklets or discussants in any locality that desires such;
2. Constructive efforts made to solve the malpractice insurance debacle in Michigan. At this writing, young surgery specialists are discouraged from coming to this state to practice, as the "big three" underwriters will not sell them malpractice policies;
3. Definitive frank discussions of quackery and pseudo-professional groups that are allowed to "practice" by our present legislators. Fifty years of being polite and discreet have only convinced the public that the cultists must not be "that bad." We all see cases that have been grossly mishandled and misdiagnosed. Isn't it time the groups that advertise and hawk their wares so blatantly, have the results of their bungling laid out for public inspection?

We are a large group of overworked, but conscientious practitioners, who would like to see some of the time saving, productive shortcuts in our state and local framework that we've all had to implement in our practices. One or the other must be out of step with the times.

Sincerely,
John E. Doolittle, M.D.
Niles

Doctor Cretens Replies To Head Start Article With Her Own Research

To the Editor:

In reply to "The Prevalence of Anemia in Head Start Children" by Olaf Mickelsen, Ph.D., *et al* in July, 1970, *Michigan Medicine.*

I would like to report my findings on hemoglobin testing in children and at the same time make a plea that physicians do more hemoglobin screening in children below school age. Also, dietary counselling does make an impact on mothers of this age group and physicians, or their aides, or Public Health Departments might well devote more time to this also.

In the past several years our Delta-Menominee District Health Department has done hemoglobin testing on approximately three or four thousand children in preschool, head start, and well child clinics. These children are Caucasian and Indian children from all economic levels.

Using a 10.5 gram hemoglobin separation level, we have come up with approximately a 15-20-25% "anemia" group. The percentage has been decreasing the past two years, hopefully due to counselling and better general diet enjoyed by all families.

The general tip-offs in the history of these anemic children include: prematurity, mother anemic during pregnancy, anemic siblings, multiple food dislikes, chronic infections, father working in another area, and poor dietary habits. It appears the last one, the "luncher," is quite important. This is the child who will not eat at the table, but gets up and raids the cookie jar or refrigerator. Oftentimes, in addition, the mother does not make any regular meals. All of the anemic children referred to in this paragraph respond well to iron and improvement of dietary patterns. During and after treatment, the parents also uniformly note the difference in their children's behavior and appetite.

An article that was published in a journal some time ago stated that the correction of anemia did as much to improve the scholastic accomplishments of primary school children as formal "Head Start" programs.

In summary—a simple hemoglobin test on youngsters has a high yield and treatment helps the kids to be brighter and healthier.

Sincerely,
Mary L. Cretens, M.D., Director
Delta-Menominee District Health Dept.

Doctor Reizen Pleased With MSMS Delegates' Support of Legislation

James B. Blodgett, M.D.
Speaker of the House
Michigan State Medical Society

Dear Doctor Blodgett:

I am pleased that the House of Delegates of the Michigan State Medical Society has voiced its concern about the problems of drug abuse treatment in Michigan.

The Michigan Department of Public Health is concerned about the lack of funding for treatment programs for drug abusers other than those provided for heroin abusers. There appears to be little consideration being given to the treatment of the non-narcotic drug abusers (hallucinogen, barbiturate, amphetamine abuses, etc.).

Hopefully, funding can be provided to fill this treatment gap and we truly appreciate the Michigan State Medical Society's support of legislation for this purpose.

Sincerely,
Maurice S. Reizen, M.D.
Director

Specialized Service
IN
PROFESSIONAL LIABILITY INSURANCE
is a high mark of distinction
THE
MEDICAL PROTECTIVE COMPANY
FORT WAYNE, INDIANA
Professional Protection Exclusively since 1899

DETROIT OFFICE: R. K. Wind and J. K. Galloway, Representatives
27200 Lahser Road, Southfield 48075, Telephone: (Area Code 313) ELgin 3-4848 or 444-1439

GRAND RAPIDS OFFICE: G. J. Haworth, Representative
422 Federal Square Building, Grand Rapids 49502 Telephone: 616-454-4477

Gone with the wind

The gas/acid group of disorders

"The two most common complaints referable to the upper gastrointestinal tract for which patients seek medical relief are hyperacidity and 'gas.' The two often occur together."*

Frees captured gas...neutralizes free acid

SILAIN-GEL Tablets and Liquid are separate formulas designed to provide equivalent dual-action symptomatic relief. Both dosage forms contain simethicone which effectively frees trapped gas, enabling the patient to eliminate it. Magnesium hydroxide in both assures a rapid rise in pH for prompt relief of hyperacidity. The special co-dried aluminum hydroxide/magnesium carbonate gel in the tablets assures the same rapid and uniform reaction rate as the liquid. Thus, both medications achieve prompt and prolonged neutralization of free acid *plus* prompt relief from the pain and pressure of trapped gas.

Always in good taste

The pleasant, distinctive flavor of SILAIN-GEL, as well as its non-constipating feature, make it a therapy your patients can live with—in comfort and without complaint.

Select the form of SILAIN-GEL you want to provide symptomatic relief in:
gastric ulcer • duodenal ulcer • heartburn • gastric hyperacidity • gastritis • dyspepsia

when the patient prefers the convenience of a tablet, select

Silain-Gel® Tablets:

when the patient prefers a liquid, select

Silain-Gel® Liquid

Also available for the patient who needs an antifrothicant/antiflatulent agent only: **Silain®** (simethicone) Tablets

*Slanger, A.: Med. Times *94*:150 (Feb.) 1966.

Announcing the "Antgasid"

Silain-Gel®

Tablets: simethicone plus aluminum hydroxide/magnesium carbonate co-dried gel and magnesium hydroxide
Liquid: simethicone plus aluminum hydroxide and magnesium hydroxide

one dose does both: frees captured gas...neutralizes free acid

A·H·ROBINS A.H. Robins Company, Richmond, Virginia 23220

Drip stopped, Congestion cleared

For upper respiratory allergies and infections, up to 12 hours clear breathing on one tablet. Dimetapp Extentabs® does an outstanding job of helping to clear up the stuffiness, drip and congestion of colds and upper respiratory allergies and infections. Each Extentab keeps working up to 12 hours. And for most patients drowsiness or overstimulation is unlikely.

INDICATIONS: Dimetapp is indicated for symptomatic relief of the allergic manifestations of respiratory illnesses, such as the common cold and bronchial asthma, seasonal allergies, rhinitis, conjunctivitis, and otitis. CONTRAINDICATIONS: Hypersensitivity to antihistamines. Not recommended for use during pregnancy. PRECAUTIONS: Until patient's response has been determined, he should be cautioned against engaging in operations requiring alertness. Administer with care to patients with cardiac or peripheral vascular diseases or hypertension. SIDE EFFECTS: Hypersensitivity reactions including skin rashes, urticaria, hypotension and thrombocytopenia, have been reported on rare occasions. Drowsiness, lassitude, nausea, giddiness, dryness of the mouth, mydriasis, increased irritability or excitement may be encountered. DOSAGE: 1 Extentab morning and evening. SUPPLIED: Bottles of 100 and 500.

A·H·ROBINS

A. H. Robins Company
Richmond, Va. 23220

Dimetapp Extentabs®

Dimetane® (brompheniramine maleate), 12 mg.; phenylephrine HCl, 15 mg.; phenylpropanolamine HCl, 15 mg

about doctors

Two Michigan Doctors To Lead PTA Workshops

Two Michigan physicians will play prominent roles in an in-depth conference entitled "Michigan Concern for Children and Youth," planned Nov. 5-6 at Cobo Hall, Detroit. Sponsors are the Michigan Congress of Parents and Teachers and the Michigan Probate and Juvenile Court Judges' Association.

Specifically designed for parents, teachers, youth and concerned citizens, the conference will include eight two-day workshops on specific topics.

Richard C. Bates, M.D., Lansing, chairman of the MSMS Committee on Alcohol and Drug Dependence, will lead the workshop entitled "How to Detect Drug Abuse in Children"; while William A. Decker, M.D., director of Children's Services at Kalamazoo State Hospital, will head the meeting on "How to Locate Psychiatric and Medical Care for Children."

Maurice S. Albin, M.D., Ann Arbor,

senior associate director of clinical therapeutics for Parke, Davis and Co. in Ann Arbor, is new chairman of the Commission of Neuroanesthesia of the World Foundation of Neurology.

Sidney B. Jenkins, M.D., Detroit,

is new medical superintendent of the state's Mental Health Drug Abuse Center located at the former U.S. Marine Hospital in Grosse Pointe Park. Doctor Jenkins, appointed by E. Gordon Yudashkin, M.D., state mental health director, was formerly director of the psychiatric division of Wayne County General Hospital.

J. Paul Klein, M.D., Fremont,

has retired from active medical practice after serving his community 24 years. Doctor Klein is former chief of medical staff at Gerber Memorial Hospital, Fremont; past president and secretary of the Newaygo County Medical Society, is a charter member of the AAGP and has been an MSMS delegate since 1947.

Thomas McEachern, M.D.,

Ann Arbor pediatrician for over 36 years, has taken a new position with the Navajo Health Station in Arizona.

Herbert A. Raskin, M.D., Detroit,

member of the AMA Committee on Alcoholism and Drug Dependence, presented the AMA's views on HR 17269, the Narcotic Addict Rehabilitation Act of 1970, before Subcommittee No. 4 of the U.S. House Judiciary Committee.

Walter G. Rice, M.D.,

former director of the division of operational studies of the Association of American Medical Colleges, has been named director of the Office of Medical Center Planning at the University of Michigan. He will be responsible for organizing the future resources of the medical center and coordinating the long-range planning needs of health care facilities with the university.

Joseph A. Rinaldo, Jr., Detroit,

is new president of the Detroit Gastroenterological Society. Other new officers are William Moss, M.D., president-elect; Bernard M. Schuman, secretary-treasurer.

Arthur E. Schulz, M.D., East Lansing,

is new president of the Michigan Ophthalmological Society. He succeeds John W. Henderson, M.D., of Ann Arbor and is chief of eye surgery at St. Lawrence Hospital, Lansing.

Albert J. Silverman, M.D.,

formerly chairman of the Department of Psychiatry at Rutgers University, has been appointed chairman of the Department of Psychiatry and Director of the Neuropsychiatric Institute at the University of Michigan.

Dr. Pollard

Dr. Pollard Named Head Of World Group

H. Marvin Pollard, M.D., professor of internal medicine and head of the section of gastroenterology at the University of Michigan Medical Center, was elected president recently of the World Organization of Gasteroenterology in Copenhagen. Doctor Pollard had previously served eight years as treasurer of the organization.

Mead Johnson—pharmaceuticals created for your specialized clinical needs

new solution...
to help your patients open mucus-clogged airways

new 10% solution...
particularly convenient for home use

MUCOMYST®-10
(ACETYLCYSTEINE)

liquefies thick, viscid mucus in chronic bronchitis and emphysema

Mucomyst, as 20% acetylcysteine, has been used with safety and effectiveness in hospitals for over five years.

Now a new 10% solution, Mucomyst-10, offers you the choice of prescribing a lesser concentration whenever you feel this is desirable. It provides added convenience and simplicity, particularly for your patients using nebulizing units at home.

By including Mucomyst-10 in the home management regimen, you can provide full mucolytic benefits for many of your patients with chronic bronchitis and emphysema complicated by tenacious secretions.

Indications: Mucomyst has been demonstrated to be clinically effective as adjuvant therapy in a wide range of conditions in which thick, viscous mucus is a problem, including: postoperative atelectasis and pneumonia; chronic bronchopulmonary disease (emphysema, chronic bronchitis, asthma, and bronchiectasis); acute bronchopulmonary disease (pneumonia, bronchitis, and tracheobronchitis); tracheostomy care; facilitation of bronchial studies; maintenance of an open airway during anesthesia; and to help control pulmonary complications of cystic fibrosis. **Contraindications:** Mucomyst is contraindicated in those patients who are sensitive or who have developed a sensitivity to it. **Warnings: After proper administration of acetylcysteine, an increased volume of liquefied bronchial secretions may occur. When cough is inadequate, the open airway must be maintained by mechanical suction if necessary. When there is a large mechanical block due to foreign body or local accumulation, the airway should be cleared by endotracheal aspiration, with or without bronchoscopy. Asthmatics under treatment with Mucomyst should be watched carefully. If bronchospasm progresses, this medication should be immediately discontinued. Adverse Effects:** Adverse effects have included stomatitis, nausea and rhinorrhea. Sensitivity and sensitization to Mucomyst have been reported very rarely. A few susceptible patients, particularly asthmatics (see **Warnings**), may experience varying degrees of bronchospasm associated with the administration of nebulized acetylcysteine. Most patients with bronchospasm are quickly relieved by the use of a bronchodilator given by nebulization. **Administration & Dosage:** Mucomyst may be administered by nebulization into a tent, Croupette, face mask, or mouthpiece; or by direct instillation. **Mucomyst should not be placed directly into the chamber of a heated (hot-pot) nebulizer.** Complete details on dosage, administration, and compatibility are included in the package insert. Additional information may be obtained from Mead Johnson Laboratories. **Supplied: Mucomyst-10 (acetylcysteine)**, a sterile 10% solution, in vials of 10 ml. and 30 ml.; **Mucomyst (acetylcysteine)**, a sterile 20% solution, in vials of 10 ml. and 30 ml.

MeadJohnson
LABORATORIES

69 MEAD JOHNSON & COMPANY • EVANSVILLE, INDIANA 47721 70469

county societies

Newaygo Doctors Donate Hospital Equipment

Gerber Memorial Hospital of Fremont has $700 worth of new medical instruments thanks to a recent donation of the same amount from the Newaygo County Medical Society. The contribution represented a $1 token fee charged for physical examinations for all local young people who were planning to attend summer camps. Medical society physicians examined nearly 700 youngsters at a special clinic set up at Fremont High School in cooperation with the Public Health Department and 4-H extension groups.

Legislators Attend Bay-Arenac-Iosco Meeting

Four state legislators from the area were invited to attend the Sept. 9 meeting of the Bay, Arenac, Iosco Counties Medical Society. They were Robert Traxler, Bay City; George A. Prescott, Tawas City, and Robert Richardson and Jerry Hart of Saginaw. Each was given five minutes to present his views on problems of the day, such as aid to schools, a graduating income tax and medical problems.

Berrien Physicians Aid Local Hospital

Benton Harbor-St. Joseph area physicians who belong to the Southwestern Michigan Academy of Medicine donated $300 recently to the Medical Education Committee of Mercy Hospital in Benton Harbor. The money is to be used to promote and sustain the postgraduate medical education program now provided at the hospital for the benefit of physicians, nurses and paramedical personnel for the tri-county area of Berrien, Van Buren and Cass. In the past, the academy has brought speakers on medical subjects to the community and sponsored programs to promote medicine as a career.

Public Arthritis Forum Alpena Doctors' Project

A public forum on the different types of arthritis and new methods of treating them was held at 8 p.m. Sept. 23 at Alpena High School by members of the Alpena-Alcona-Presque Isle Counties Medical Society. Bruce Omart, M.D., and Stuart Cohn, M.D., of Alpena, joined John Sigler, M.D., of Henry Ford Hospital, in a panel discussion, followed by questions and answers from the audience. The forum is an outgrowth of a quarterly series of symposiums on arthritis begun six months ago by the medical society. The symposia are for physicians at Alpena General Hospital and feature two or three consulting physicians from Detroit or Ann Arbor, who spend a day in Alpena assisting the local medical staff.

Educational Program Held by Hillsdale M.D.s

"Enzymes, Thyroid Tests and Immunoglobulins" was the topic of the educational program planned Sept. 2 by the Hillsdale County Medical Society. Guest speakers were Roland Imperial, M.D., and H. A. Kallet, M.D., of Foote Hospital in Jackson.

Washtenaw Physicians Train Ambulance Personnel

Physicians and surgeons representing the Highway Safety Committee of the Washtenaw County Medical Society and surgeons of the Ann Arbor Chapter of the American College of Surgeons recently provided a training program for ambulance personnel, police, and firemen. Approximately 40 men attended a series of lectures, one night each week for four months. This course was under the direction of Charles Frey, M.D., and the faculty of 28 physicians and surgeons included psychiatrists, and internists. Course planners believe it is imperative that physicians and surgeons assume the responsibility for training personnel concerned with the initial management of the acutely ill or injured. Interested physicians may have an outline of the course by writing to Doctor Frey.

The September Issue . . .

of *Michigan Medicine* contained several important articles worth the doctor's time to read. Among them were a scientific paper on a comparison of two inpatient treatment methods for heroin addiction, a report on the new SAMA-sponsored program to place medical students in community hospitals, a special article on a project of Michigan physicians to aid the impoverished of Fayette, Miss., and a list of postgraduate courses for 1970-71 at the University of Michigan Medical Center.

Pat Hudson has angina.
But he hardly ever thinks about it.

New

STEPS™

PENTAERYTHRITOL TETRANITRATE

Timed Disintegration Capsules

Give him prophylaxis against angina pectoris
Convenience of twice-a-day dosage
Greater peace of mind

Each capsule is designed to provide vasodilating effect for up to 12 hours. Conventional dosage forms of pentaerythritol tetranitrate (PETN), which must be taken every 3 to 4 hours, keep some patients reminded of their disability throughout the day. And some, taking short-acting dosage forms, become quite apprehensive about being without medication while asleep.

Dosage range that now lets you control nitrite therapy.

STEPS pentaerythritol tetranitrate timed disintegration capsules not only give the patient more convenience and peace of mind, they let you prescribe the dose an individual patient needs.

STEPS comes in 3 potencies—30 mg. 50 mg. and 80 mg.—to help you determine the optimal level of effectiveness in providing relief from the frequency and intensity of anginal attacks.

The wide potency range of STEPS allows you to adjust the dosage to meet the patient's needs. Moreover, if therapy must be altered or discontinued due to nitrite tolerance, the flexible dosage of STEPS permits resumption of therapy at the smallest effective dose.

(See next page for complete dosage recommendations and precautions.)

New

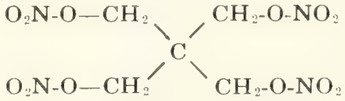
STEPS™ PENTAERYTHRITOL TETRANITRATE

Timed Disintegration Capsules

Available in three potencies for greater dosage flexibility and better control of therapy.

CAUTION: Federal law prohibits dispensing without prescription.

DESCRIPTION: Pentaerythritol Tetranitrate Structural Formula:



Empirical Formula: $C_5H_8N_4O_{12}$ Molecular Weight: 316.15. The pentaerythritol tetranitrate is in a special timed disintegration base providing for prolonged therapeutic effect.

MODE OF ACTION: The mechanism of action in the relief of angina pectoris is unknown at this time, although the basic pharmacologic action is to relax smooth muscle.

INDICATIONS: For the relief of angina pectoris (pain of coronary artery disease). It is not intended to abort the acute anginal episode, but is widely regarded as useful in the prophylactic treatment of angina pectoris.

CONTRAINDICATIONS: Idiosyncrasy to this drug.

WARNINGS: Data supporting the use of nitrites during the early days of the acute phase of myocardial infarction (the period during which clinical and laboratory findings are unstable) are insufficient to establish safety. Keep out of reach of children.

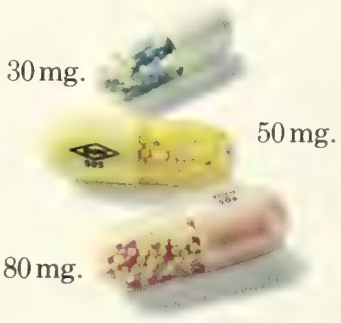
PRECAUTIONS: Intraocular pressure is increased; therefore, caution is required in administering to patients with glaucoma. Tolerance to this drug, and cross-tolerance to other nitrites and nitrates may occur.

ADVERSE REACTIONS: Cutaneous vasodilation with flushing. Headache is common and may be severe and persistent. Transient episodes of dizziness and weakness, as well as other signs of cerebral ischemia associated with postural hypotension, may occasionally develop. This drug can act as a physiological antagonist to norepinephrine, acetylcholine, histamine, and many other agents. An occasional individual exhibits marked sensitivity to the hypotensive effects of nitrite and severe responses (nausea, vomiting, weakness, restlessness, pallor, perspiration and collapse) can occur, even with the usual therapeutic dose. Alcohol may enhance this effect. Drug rash and or exfoliative dermatitis may occasionally occur.

DOSAGE AND ADMINISTRATION: One capsule every 12 hours on an empty stomach. (Not recommended for sublingual use.)

HOW SUPPLIED: STEPS pentaerythritol tetranitrate timed disintegration capsules are available in 30 mg. (NDC 183-504-2), 50 mg. (NDC 183-505-2), and 80 mg. (NDC 183-506-2) sizes. Each capsule size is packaged in bottles of 100.

STORAGE: Capsules should be stored in a cool, dry place in a light-resistant container out of the reach of children.



DOW

THE DOW CHEMICAL COMPANY
Rx Pharmaceuticals, Indianapolis

special articles

Role of Society of Pediatric Research To Emphasize Value of Child Health Study

By William B. Weil, Jr., M.D.
President,
Society for Pediatric Research

The Society for Pediatric Research now numbers approximately 400 active members and an equal number of emeritus ones was founded in 1929 by a small group of academically-oriented pediatricians. The society was formed so that young physicians could meet together on a regular basis and discuss their research programs. Since that time the Society has included in its membership most everyone of note in the United States who has worked on research problems in pediatrics.

The membership is based on nomination by members of the Society and is open to all physicians who are actively engaged in research investigation related to child health and human development. The great majority of the members are pediatricians who are on the full-time faculties of the various medical schools of this country, but there are also physicians in practice, surgeons, physiologists, psychiatrists and psychologists. Members become emeritus at 45 years of age and as a result the society is in many ways comparable to the American Society for Clinical Investigation among the internists.

Although the society was originally formed simply as a forum for research investigators to present and discuss their work, the nature of the organization has changed considerably over the last 10 years. In that period the Society has joined with the American Pediatric Society and the European Club for Pediatric Research to sponsor an international journal entitled *Pediatric Research* which is now flourishing.

In addition the Society for Pediatric Research was a prime mover in the formation of the Joint Council of National Pediatric Societies. The joint council is made up of representatives from the Society for Pediatric Research, the American Pediatric Society, the Association for Medical School Pediatric Department Chairmen, the Association of Professors of Maternal and Child Health and the American Academy of Pediatrics. The joint council has been the public policy and liaison arm of the Society for Pediatric Research for the last three years. As a result of activities of this type the Society for Pediatric Research has been closely identified in some of its activities with the American Pediatric Society and with the American Academy of Pediatrics.

The Society for Pediatric Research holds its annual meetings in Atlantic City at the end of April and in conjunction with the American Pediatrics Society. On the average there have been approximately 400 research papers submitted for the annual meeting and approximately 125 of these are presented in either plenary sessions of the total society or at specialty sections. Approximately 2,500 people attend the combined meetings of the SPR and the APS and this year there will be 14 sub-sections meeting for one day. For the last few years these meetings have just preceded those of the American Federation for Clinical Research, the American Society for Clinical Investigation and the American Association of Physicians. This year for the first time the Society for Pediatric Research and the American Federation for Clinical Research are sponsoring two joint seminars.

Doctor Weil is the president of the Society for Pediatric Research, and is also professor and chairman of the Department of Human Development of Michigan State University.

This and the following article are part of a new series begun in the September issue of *Michigan Medicine*. The articles are contributed by the Michigan physicians who are presidents of national medical associations. The journal will continue to print articles written by other Michigan presidents of national medical organizations, as they decribe the concepts, purposes and new trends of their respective groups.

The major over-all goal of the Society for Pediatric Research is to foster and encourage investigations that are designed to improve the health, the society has an increasingly important of individuals involved in research related to child health, the society has an increasingly important role to play in view of current national attitudes, in informing the public, the scientific community and the government of the great significance that continuing research efforts will have on the ultimate improvement of child health and thereby the health of the adult population in the entire country.

American Psychiatric Association Prime Force In Raising Status of Psychiatry

By Raymond W. Waggoner, M.D.
President, American Psychiatric Assn.

The American Psychiatric Association is the oldest national medical society in the United States, having been founded in 1844 by 13 superintendents of mental hospitals. Since 1960 its membership, now over 17,000, has increased sevenfold. It is the third largest medical specialty society, exceeded only by the American Academy of General Practice and the American College of Surgeons. Qualified psychiatrists in North and Central America and the Caribbean are eligible to join; but of course the bulk of its members are residents of the U.S.

All of the powers of the association are vested in the voting members assembled in an annual meeting in May. Between meetings the powers are exercised by 19 elected trustees, including 7 officers and 12 others, six of whom represent the six areas of the Assembly of District Branches. The assembly comprises elected delegates from 63 Branches in all parts of the country. It is a "grassroots" deliberative body whose opinions play an ever more telling role in shaping the association's programs and policies.

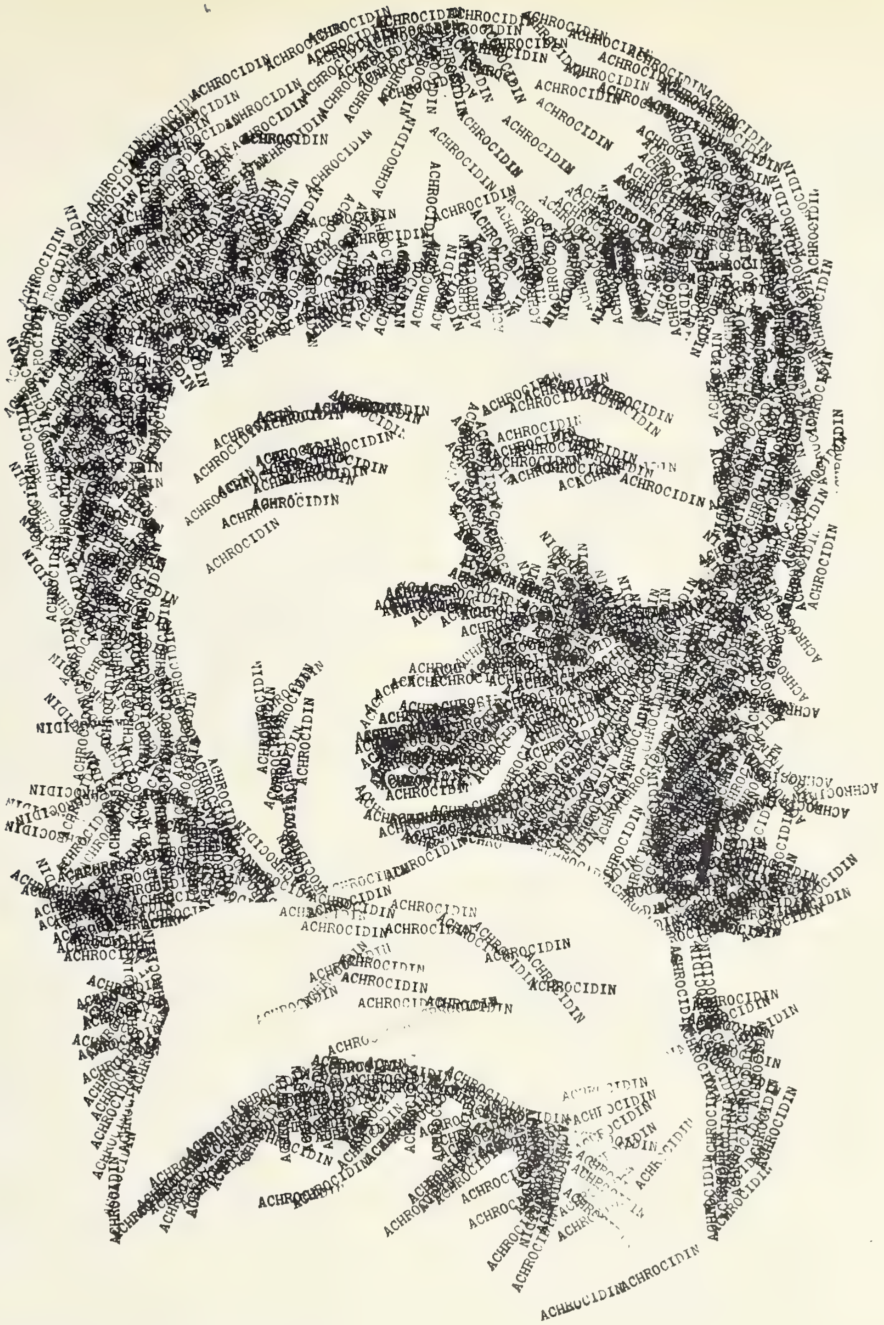
By and large the association's positions and programs originate in the studies and recommendations of over 100 committees and task forces which function under the aegis of six councils of five members each appointed by the president. The names of the six councils are rubrics under which the many-faceted interests of the Association can be grouped, namely: medical education and career development, mental health services, research and development, national and international affairs, professions and associations, and internal organization. In very recent years the committee structure has undergone fundamental revision by way of rendering the association more responsive and more viable in coping with the many demands being made on it from within and without. The former standing committee structure is being largely eliminated. New task forces are appointed only to carry out a specific task, and they are terminated upon its completion.

All of the above components are served by a staff of about 100, including six psychiatrists, at APA headquarters in Washington, D.C. under our distinguished Medical Director, Walter E. Barton, M.D. Here are published the *American Journal of Psychiatry,* the *Journal of Hospital and Community Psychiatry,* and a lively monthly newspaper *Psychiatric News.* The last named is a particularly vital instrument for keeping the entire membership simultaneously informed of major developments affecting the profession. The headquarters staff also administers extensive public information activities, a physician education program, a self-assessment program for all members, legislative analysis and liaison, state surveys of mental health needs and resources, and the editorial processing of many publications such as the *Diagnostic and Statistical Manual of Mental Disorders.* The staff conducts liaison activities with many related organizations and agencies, the American Medical Association and the American Hospital Association, for example.

There can be no doubt that the Association has been the most telling single force over the last quarter century in bringing psychiatry to the status it enjoys today within the medical community and, indeed, in American society as a whole. The growing influence of psychiatry in medical education, the rapid development of psychiatry in general hospitals, and the advent of the community mental health movement, for example, suggest how far psychiatry has departed the isolation that so characterized mental hospital and private office practice a few decades ago. It is our hope that the 1970s will witness a quickening diminution of the separatism of mental health

(Continued on Page 932)

Doctor Waggoner is immediate past president of the American Psychiatric Association and is also president of the Neuropsychiatric Institute, University of Michigan Medical Center.



Achrocidin® Tablets and Syrup

Tetracycline HCl—Antihistamine—Analgesic Compound

Each tablet contains: ACHROMYCIN® Tetracycline HCl 125 mg.; Phenacetin 120 mg.; Caffeine 30 mg.; Salicylamide 150 mg.; Chlorothen Citrate 25 mg.

ACHROCIDIN Tetracycline HCl—Antihistamine—Analgesic Compound Tablets and Syrup are recommended for the treatment of tetracycline-sensitive bacterial infection which may complicate vasomotor rhinitis, sinusitis and other allergic diseases of the ipper respiratory tract, and for the concomitant symptomatic relief of headache and nasal congestion. For children and elderly patients you may prefer caffeine-free ACHROCIDIN Syrup. Each 5 cc contains: ACHROMYCIN Tetracycline equivalent to Tetracycline HCl 125 mg.; Phenacetin 120 mg.; Salicylamide 150 mg.; Ascorbic Acid (C) 25 mg.; Pyrilamine Maleate 15 mg.

Contraindications: Hypersensitivity to any omponent.
Varning: In renal impairment, since liver toxicity is possible, lower doses are indicated; durng prolonged therapy consider serum level leterminations. Photodynamic reaction to sunight may occur in hypersensitive persons. hotosensitive individuals should avoid expoure; discontinue treatment if skin discomfort ccurs.
recautions: Drowsiness, anorexia, slight gasric distress can occur. In excessive drowsiess, consider longer dosage intervals. Persons on full dosage should not operate vehicles. Nonsusceptible organisms may overgrow; treat superinfection appropriately. Treat beta-hemolytic streptococcal infections at least 10 days to help prevent rheumatic fever or acute glomerulonephritis. Tetracycline may form a stable calcium complex in bone-forming tissue and may cause dental staining during tooth development (last half of pregnancy, neonatal period, infancy, early childhood).
Adverse Reactions: *Gastrointestinal*—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. *Skin*—maculopapular and erythematous rashes; exfoliative dermatitis; photosensitivity; onycholysis, nail discoloration. *Kidney*—dose-related rise in BUN. *Hypersensitivity reactions*—urticaria, angioneurotic edema, anaphylaxis. *Intracranial*—bulging fontanels in young infants. *Teeth*—yellow-brown staining; enamel hypoplasia. *Blood*—anemia, thrombocytopenic purpura, neutropenia, eosinophilia. *Liver*—cholestasis at high dosage.
Upon adverse reaction, stop medication and treat appropriately.

Lederle LEDERLE LABORATORIES, A Division of American Cyanamid Company, Pearl River, New York 10965

534-9

from other health concerns and the association will work to that end.

It is impossible in so short an article to detail the range of the Association's programs and activities. We would mention, however, that a priority concern at the moment has to do with the nation's health delivery system, or lack of a system. The APA has established a blue ribbon Commission on the Delivery of Mental Health Services comprising eight leading psychiatrists and numerous expert consultants from government, medicine, finance, administration, systems engineering, and social science. The commission's study will, of course, concentrate on the delivery of mental health services; but its findings, to be reported over the next two to five years, will have ramifications for all of medicine. We are hopeful that medicine in general will lend them a sympathetic ear.

Suicide Prevention In Detroit

By Bruce L. Danto, M.D.
Director, Detroit
Suicide Prevention Center

In 1958 two psychiatrists from Detroit, T. Petty, M.D., and Viggo Jensen, M.D., published their findings regarding suicide in Detroit and laid the foundation for the suicide prevention movement. They observed that prior to committing suicide, people turn to another person, possibly even a stranger, whom they identify as their rescuer. In instances where the suicide was successful, it was obvious that the rescuer was unaware of his acquired role or untrained to handle that role. It was apparent that there was a need for a public rescuer, a person or persons trained to help the potential suicide, to hear his cry for help.

However, in December 1967, nothing successful had been done about the suicide problem or about creating a rescuer. At that point, Bruce Danto, M.D., began a campaign to establish a suicide prevention center in Detroit. After consulting with the Los Angeles Suicide Prevention Center, the first center in the United States, he sent out letters, talked before groups in the community, approached citizens for help and money and ran fund-raising affairs so that the center could open. After recruiting volunteer citizens, whom he screened and trained over an eight-week period, the Center opened officially on November 8, 1968. Since that time, the Center has provided 24-hour "rescuer" service to the Tri-County area.

During the first 12 months of operation, the Center's volunteers handled over 3,000 calls. Of those, 50% concerned suicide related cries for help. The remaining 50% included threatened homicide, problems of the aged who require nursing home placement or are lonely, young people on drugs or alcohol, lonely people or ones who are slowly dying from a terminal illness and need to verify their state of being alive.

It can be assumed with reasonable safety that all those who call are lives saved. Why? Because the callers are followed-up and checked to make sure they're under control or have contacted the agency to which they have been referred. Many callers, in turn, contact the Center to offer progress reports as well as messages of thanks.

The callers may maintain their anonymity and no charge for service is made.

Notwithstanding the successes, it is known that six callers did commit suicide.

We don't like death and we do not take comfort from small suicide figures. One death affects a whole family, company, town and even a country. We know that we handle calls well and that our callers are pleased with the service. But, what about the people who don't know we're available or who, for other reasons, don't call us?

These are the ones who end up in the morgue, people who should not be there. These are the ones who are called suicide or accident or unexplained death. Sometimes they are called heart attack or stroke. For our community, they represent a tragic waste of productive life.

The Suicide Prevention Center conducted a campaign during July focused on these unseen people who quietly and sometimes dramatically destroy themselves. The people we were after are the adults, the ones whose suicide rate climbs during the long, hot, laid-off from the plant, type of summer. They don't know about us.

In August, we aimed at the kids. Their statistics show a rise in September, possibly because of school and the pressure of responsibility, possibly because of the feeling of unbearable aloneness they experience while sitting in a crowded classroom. These are the kids who all year-round fill the emergency rooms of hospitals; these are the kids who come in second in the number of suicides, second only to the group from ages 20-35.

We wanted them to give us a chance. We can help.

Lectro-pads
They work best together!

BURDICK ELECTROCARDIOGRAPHS AND BURDICK ECG SUPPLIES

The electrocardiogram must be diagnostically accurate and clear in every detail because it is a permanent record of the patient's condition. The Burdick EK 4 is designed to give you this accuracy and dependable service-free performance. To insure this, use only supplies designed specifically to work with Burdick ECG equipment. Burdick EK 10 paper is designed so that paper coating will not be picked up to distort accuracy or shorten stylus life. EK-19 Lectro-pads offer neat, quick electrode applications. Burdick ECG mounts facilitate filing of patient records.

Remember — your cardiograph is only as good as the accessories you use with it. Ask your Burdick dealer about the EK 4 and our complete line of ECG supplies, or write **The Burdick Corporation, Milton, Wisconsin 53563** for further details and technical information.

BURDICK

THE G. A. INGRAM COMPANY
4444 Woodward Avenue, Detroit, Michigan 48201
Telephone: TEmple 2-4444

painless intramuscular therapy for calcium deficiencies:

Calphosan®
calcium glycerophosphate, calcium lactate

To bring effective calcium therapy to the patient, Calphosan may be administered intramuscularly . . . without pain, inflammatory reactions, induration or sloughing. Injections twice weekly for a series of 5 to 10 injections are recommended.

Average dose per injection: One or two 10 ml. injections of Calphosan each week for the first four or five weeks, and on a when-needed basis thereafter.

Calphosan is a specially processed solution of calcium glycerophosphate and calcium lactate, containing 1% of each, in a physiological solution of sodium chloride. Each 10 ml. contains 50 mg. of calcium glycerophosphate, 50 mg. calcium lactate, with 0.25% phenol as preservative. Available in 10 ml. ampules in boxes of 10s and 100s; 60 ml. multiple-dose vials. Also available as Calphosan with B-12. U. S. Patent No. 2657172.

Contraindication: Hypercalcemia; neoplastic diseases; and fully digitalized patients. Do not use intramuscularly in infants and young children. Before starting therapy, consult complete product literature.

Write for free copy of "Calcium: The Ubiquitous and Essential Element" and for samples.

THE CARLTON CORP
Tenafly, New Jersey 07670

medico-legal

(Editor's Note: The following items are quoted from the AMA CITATION newsletter of July 1, 1970, prepared by the AMA Law Department.)

Statute of Limitation Applies to Wrongful Death Action

In a suit against a hospital filed by relatives of a patient under a wrongful death statute, a Michigan appellate court held that such a claim (or notice of intent to file a claim) must be filed within six months after the event that gave rise to the cause of action took place.

The patient, while at the hospital, was injured in a fall on March 26, 1965. As a result of injuries suffered in the fall, she died on April 29, 1965. This case was filed on April 25, 1968, and no claim or notice of intention to file a claim preceded this action.

The hospital asked for and received a summary judgment on the basis that a statute required that a claim or notice of intention to file a claim must be filed within six months after the cause of action arose. The patient appealed.

The court held that the statute of limitation of six months was applicable to wrongful death actions, and thus the lower court's decision was upheld. – *Wilson* v *State of Michigan,* 172 N.W. 2d 891 (Mich. Ct. of App., Oct. 28, 1969)

Charitable Immunity Extends to Hospital's Failure to Raise Bedrail

Charitable immunity was a valid defense by a hospital, a Michigan appellate court held, against a patient's claim of injury caused by failure to put guard rails up on a bed when the patient was under heavy sedation.

The patient entered the hospital May 25, 1959, and on the following day surgery was performed. Upon her return from surgery she was visited by her husband and a sister-in-law, who observed that the patient was in a sedated condition and that there were neither guard rails nor bars around the bed. When the patient's husband returned on May 27, 1959, he discovered that she had broken her hip and had been placed in traction. Proof indicated that while the patient was under sedation she had fallen from the bed and suffered the injuries complained of.

In examination of the record, the reviewing court found the only evidence regarding the condition of the bed to be statements demonstrating negligence in failing to put up the guard rails. This was not proof of a defective instrumentality and it was not of a sufficient nature to overcome the defense of charitable immunity which had been raised on behalf of the hospital. (The court pointed out, however, that charitable immunity was abolished in Michigan in 1960, after this cause of action accrued.) – *Denno* v *Providence Hospital,* 172 N.W. 2d 918 (Mich. Ct. of App., Oct. 27, 1969) *from Vol. 21, No. 6*

(Editor's Note: The following article is quoted from the AMA CITATION newsletter of June 15, 1970, prepared by the AMA Law Department.)

Photograph of Injuries Admissible

In a woman's suit for injuries sustained in an automobile accident, a trial court did not abuse its discretion in admitting in evidence a photograph of the injuries to her face, a Michigan appellate court ruled. The photograph was taken immediately after her arrival at the hospital following the accident. The photograph's probative value with respect to material issues in the case outweighed any prejudicial effect that it might have.

The photograph showed the woman's face covered with blood and a mass of small and large and jagged lacerations, her nose smashed and almost completely torn from its position.

The admissibility of a photograph is for the sound discretion of the trial court. A photograph must, of course, be accurate and have probative value. The photograph must also be helpful in throwing light upon some material point in issue.

One issue before the trial court was the extent of the woman's injuries and the amount of pain and suffering that they caused her. Another issue was the amount of recovery for medical expenses incurred in treating the injuries. The photograph was necessary for a proper description of the injuries and for an explanation of the corrective treatment employed by the plastic surgeon. The photograph was thus clearly of probative value on material issues of fact. No question was raised as to the photograph's accuracy.

The negligent driver contended that the photograph should have been excluded because it was prejudicial and inflammatory.

The court said that the photograph was admittedly gruesome. However, its probative value on material issues outweighed any prejudicial effect that it might have. – *Anderson* v. *Lippes,* 170 N.W.2d 908 (Mich. Ct. of App., June 26, 1969)

from Vol. 21, No. 5

A
BUILDING BLOCK
TO RECOVERY

"Welcome back, Ann"
As adjunctive therapy
DOUBLE STRENGTH
Orenzyme®
Bitabs One tablet q.i.d.
Trypsin 100 000 N.F Units, Chymotrypsin: 8,000 N.F. Units; equivalent in tryptic activity to 40 mg. of N.F. trypsin
Reduces swelling
Hastens healing
Speeds recovery
trauma

One tablet q.i.d.

Indications: When used as adjunctive therapy for the rapid resolution of inflammation and edema, good results have been obtained in:
☐ Accidental Trauma ☐ Postoperative Tissue Reactions.
Other conventional measures of treatment should be used as indicated. In infection, appropriate anti-infective therapy should be given.
Contraindications: ORENZYME BITABS should not be given to patients with a known sensitivity to trypsin or chymotrypsin.
Precautions: It should be used with caution in patients with abnormality of the blood clotting mechanism such as hemophilia, or with severe hepatic or renal disease. Safe use in pregnancy has not been established.
Adverse Reactions: Adverse reactions with ORENZYME have been reported infrequently. Reports include allergic manifestations (rash, urticaria, itching), gastrointestinal upset and increased speed of dissolution of animal-origin surgical sutures. There have been isolated reports of anaphylactic shock, albuminuria and hematuria. Increased tendency to bleed has also been reported but, in controlled studies, it has been seen with equal incidence in placebo-treated groups. (See Precautions.) It is recommended that if side effects occur medication be discontinued.
Dosage: One tablet q.i.d.

THE NATIONAL DRUG COMPANY
DIVISION OF RICHARDSON-MERRELL INC.
PHILADELPHIA, PENNSYLVANIA 19144
TRADEMARK BITABS U.S. PATENT NO. 3,004,893 9/70 0-009A 161

Orenzyme® Bitabs

Trypsin: 100,000 N.F. Units, Chymotrypsin: 8,000 N.F. Units; equivalent in tryptic activity to 40 mg. of N.F. trypsin

The causes of vaginitis are multiple

Trichomonads . . . monilia . . . bacteria

You can depend on AVC—comprehensive therapy that combats all three major vaginal pathogens, alone or in combination.

AVC

Cream (aminacrine hydrochloride 0.2%, sulfanilamide 15.0%, allantoin 2.0%)

Suppositories (aminacrine hydrochloride 0.014 Gm., sulfanilamide 1.05 Gm., allantoin 0.14 Gm.)

Contraindications: Known sensitivity to sulfonamides.

Precautions/Adverse Reactions: The usual precautions for topical and systemic sulfonamides should be observed because of the possibility of absorption. Burning, increased local discomfort, skin rash, urticaria or other manifestations of sulfonamide toxicity are reasons to discontinue treatment.

Dosage: One applicatorful or one suppository intravaginally once or twice daily.

Supplied: Cream—Four-ounce tube with or without applicator. Suppositories—Box of 12 with applicator.

TRADEMARK: AVÇ AV-007A 7/70 Y-149

THE NATIONAL DRUG COMPANY
DIVISION OF RICHARDSON MERRELL INC
PHILADELPHIA, PENNSYLVANIA 19144

AVC
The treatment is singular

Sandoz announces...

a new agent for
the alcohol-dependent patient
who wants to quit
and
a program for the Michigan physician
who wants to help

When alcohol becomes a way of life
new SERENTIL® (mesoridazine

a major tranquilizer with specific advantages for the alcohol-dependent patient

1. Alleviates tension, anxiety, and depression; may also ease prevalent neurotic symptoms in personality disorders.
2. No reported habituation or addiction.
3. Antiemetic properties to control nausea and vomiting.
4. Has not caused hepatic dysfunction or interfered with functional recovery of impaired liver.
5. Four tablet strengths to allow flexibility of dosage (usual starting dose: for the problem drinker, 10 mg. t.i.d.; for the frank alcoholic, 25 mg. b.i.d.)
6. Injectable form available for acute episodes.

program for early recognition and successful treatment:

Alcoholism in Michigan*

State Rank

total no. alcoholics	6th
no. per capita	11th
per capita consumption†	15th

Michigan Physicians' Report
(compared with U.S. average)

	%Mich.	%U.S.
see 5 or more problem drinkers in 2-month period	44.4	37.1
half or more seen are women	29.9	37.4
treat, rather than refer	68.8	72.6
more community services needed	63.1	63.0

*based on preliminary data supplied by Center of Alcohol Studies, Rutgers Univ. †absolute alcohol

The Ins-and-Outs of Alcoholism: A series of recordings and other mailings, each concerned with a particular aspect of the alcohol problem. Recognized authorities in the field discuss the scope, recognition and treatment of alcohol-dependent patients. Also included will be **The Alcoholic Directory,** a nationwide survey of treatment centers.

Interested? Complete and mail this coupon to:

Dept. SERENTIL/Sandoz Pharmaceuticals
Route 10/Hanover, N. J. 07936

SANDOZ

Dr.____________________
(PLEASE PRINT)

Street____________________

City__________ State________ Zip________

The Alcoholic Directory

See next page for prescribing information.

SERENTIL®
(mesoridazine)
new weapon in the fight against alcoholism

INDICATIONS: In clinical studies, Serentil (mesoridazine) has been found useful in the following disease states:

Alcoholism—Acute and Chronic: Serentil ameliorates anxiety, tension, depression, nausea and vomiting in both acute and chronic alcoholics without producing hepatic dysfunction or hindering the functional recovery of the impaired liver.

Schizophrenia: Serentil is effective in the treatment of schizophrenia. It substantially reduces the severity of Emotional Withdrawal, Conceptual Disorganization, Anxiety, Tension, Hallucinatory Behavior, Suspiciousness and Blunted Affect in schizophrenic patients. As with other phenothiazines, patients refractory to previous medication may respond to Serentil.

Behavioral Problems in Mental Deficiency and Chronic Brain Syndrome: The effect of Serentil was found to be excellent or good in the management of hyperactivity and uncooperativeness associated with Mental Deficiency and Chronic Brain Syndrome.

Psychoneurotic Manifestations: Serentil reduces the symptoms of anxiety and tension, prevalent symptoms often associated with neurotic components of many disorders, and benefits personality disorders in general.

CONTRAINDICATIONS: As with other phenothiazines Serentil (mesoridazine) is contraindicated in severe central nervous system depression or comatose states from any cause. Serentil is contraindicated in individuals who have previously shown hypersensitivity to the drug.

WARNINGS: Where patients are participating in activities requiring complete mental alertness (e.g., driving), it is advisable to administer the phenothiazines cautiously and to increase the dosage gradually.

Usage in pregnancy: The safety of this drug in pregnancy has not been established; hence, it should be given only when the anticipated benefits to be derived from treatment exceed the possible risks to mother and fetus.

Usage in children: The use of Serentil in children under 12 years of age is not recommended, because safe conditions for its use have not been established.

Attention should be paid to the fact that phenothiazines are capable of potentiating central nervous system depressants (e.g., anesthetics, opiates, alcohol, etc.) as well as atropine and phosphorus insecticides.

PRECAUTIONS: While ocular changes have not to date been related to Serentil, one should be aware that such changes have been seen with other drugs of this class.

Because of possible hypotensive effects, reserve parenteral administration for bedfast patients or for acute ambulatory cases, and keep patient lying down for at least ½ hour after injection.

Leukopenia and/or agranulocytosis have been attributed to phenothiazine therapy. A single case of transient granulocytopenia has been associated with Serentil (mesoridazine).

ADVERSE REACTIONS: Drowsiness and hypotension were the most prevalent side effects encountered. Side effects tended to reach their maximum level of severity early with the exception of a few (rigidity and motoric effects) which occurred later in therapy.

With the exceptions of tremor and rigidity, adverse reactions were generally found among those patients who received relatively high doses early in treatment. Clinical data showed no tendency for the investigators to terminate treatment because of side effects.

Serentil has demonstrated a remarkably low incidence of adverse reactions when compared with other phenothiazine compounds.

Central Nervous System: Drowsiness, Parkinson's syndrome, dizziness, weakness, tremor, restlessness, ataxia, dystonia, rigidity, slurring, akathisia, motoric reactions (opisthotonos) have been reported.

Autonomic Nervous System: Dry mouth, nausea and vomiting, fainting, stuffy nose, photophobia, constipation and blurred vision have occurred in some instances.

Endocrine System: Inhibition of ejaculation and lactation have been noted rarely.

Skin: Itching, rash, hypertrophic papillae of the tongue and angioneurotic edema have been reported.

Cardiovascular System: Hypotension and tachycardia have been reported. EKG changes have occurred in some instances (see Phenothiazine Derivatives: Cardiovascular Effects).

Phenothiazine Derivatives: It should be noted that efficacy, indications and untoward effects have varied with the different phenothiazines. The physician should be aware that the following have occurred with one or more phenothiazines and should be considered whenever one of these drugs is used:

Autonomic Reactions: Miosis, obstipation, anorexia, paralytic ileus.

Cutaneous Reactions: Erythema, exfoliative dermatitis, contact dermatitis.

Blood Dyscrasias: Agranulocytosis, leukopenia, eosinophilia, thrombocytopenia, anemia, aplastic anemia, pancytopenia.

Allergic Reactions: Fever, laryngeal edema, angioneurotic edema, asthma.

Hepatotoxicity: Jaundice, biliary stasis.

Cardiovascular Effects: Changes in the terminal portion of the electrocardiogram, including prolongation of the Q-T interval, lowering and inversion of the T-wave and appearance of a wave tentatively identified as a bifid T or a U wave have been observed in some patients receiving the phenothiazine tranquilizers, including Serentil (mesoridazine). To date, these appear to be due to altered repolarization and not related to myocardial damage. They appear to be reversible.
There is no evidence at present that these change
are in any way precursors of any significant di
turbance of cardiac rhythm.

Hypotension, rarely resulting in cardiac arre
has been noted.

Extrapyramidal Symptoms: Akathisia, agitatio
motor restlessness, dystonic reactions, trismu
torticollis, opisthotonos, oculogyric crises, trem
muscular rigidity, akinesia—some of which o
rare occasions have persisted for several mont
or years especially in patients of advanced ag
with brain damage.

Endocrine Disturbances: Menstrual irregularitie
altered libido, gynecomastia, weight gain. Fals
positive pregnancy tests have been reported.

Urinary Disturbances: Retention, incontinence.

Others: Hyperpyrexia. Behavioral effects sugge
tive of a paradoxical reaction have been reporte
These include excitement, bizarre dreams, aggr
vation of psychoses and toxic confusional stat
More recently, a peculiar skin-eye syndrome h
been recognized as a side effect following lo
term treatment with phenothiazines. This reacti
is marked by progressive pigmentation of are
of the skin or conjunctiva and/or accompanied
discoloration of the exposed sclera and corne
Opacities of the anterior lens and cornea
scribed as irregular or stellate in shape ha
also been reported.

DOSAGE AND ADMINISTRATION: Oral: The d
age of Serentil (mesoridazine), as in most me
cations, should be adjusted to the needs of t
individual. The lowest effective dosage shou
always be used. When maximum response
achieved, dosage may be reduced gradually
a maintenance level.

Alcoholism: For most patients the usual starti
dose is 25 mg. b.i.d. The usual optimum to
daily dose range is 50-200 mg. per day.

Schizophrenia: For most patients, regardless
severity, a starting dose of 50 mg. t.i.d. is rec
mended. The usual optimum total daily dose ran
is 100-400 mg. per day.

*Behavioral Problems in Mental Deficiency a
Chronic Brain Syndrome:* For most patients a st
ing dose of 25 mg. t.i.d. is recommended. T
usual optimum total daily dose range is 75-300
per day.

Psychoneurotic Manifestations: For most patients t
usual starting dose is 10 mg. t.i.d. The usual o
mum total daily dose range is 30-150 mg. per d

Injectable Form: In those situations in which
intramuscular form of medication is indicat
Serentil (mesoridazine) Injectable is available.
most patients a starting dose of 25 mg. is rec
mended. The dose may be repeated in 30 to
minutes, if necessary. The usual optimum total d
dose range is 25-200 mg. per day.

HOW SUPPLIED: Tablets: 10 mg., 25 mg., 50
and 100 mg. mesoridazine (as the besylate).
tles of 100.

Ampuls: 1 cc. [25 mg. mesoridazine (as the be
ate)]. Inactive ingredients—Disodium Edet
U.S.P., 0.5 mg.; Sodium Chloride, U.S.P., 7.2 m
Carbon Dioxide Gas (Bone Dry), q.s.; Water
Injection, U.S.P., q.s. to 1 cc. Boxes of 20 and
SER70-101

Sandoz Pharmaceuticals, Hanover, N.J.

The Michigan Cancer Foundation's Role In The Third National Cancer Survey

By Michael J. Brennan, M.D.
James F. Groen, M.A.
Detroit

The metropolitan areas of Pittsburgh, Dallas-Fort Worth, Philadelphia, San Francisco-Oakland, Birmingham, Minneapolis-St. Paul, Atlanta and Detroit, along with the states of Iowa and Colorado and the territory of Puerto Rico, are included in the Third National Cancer Survey.

These areas have a 1970 projected population approximating 25 million. More than 250,000 new cases of cancer will occur in these areas during the three years of the survey, 1969-71.

In 1947-48, Detroit participated in a similar, second National Cancer Survey. The Detroit findings from that survey provided extensive and reliable information concerning cancer in an urban population. The physicians and hospital personnel, whose efforts made the 1947-48 survey possible, have received recognition from cancer epidemiologists throughout the world for their important contribution to the understanding of cancer.

Because of changes which have occurred in the environment, and in the incidence, diagnosis, treatment and mortality of cancer during the past 20 years, the findings of the 1947-48 survey are now out of date, and it is of particular importance to update the Detroit findings.

Detroit's participation in the Third National Cancer Survey has been expanded to include the three counties of Wayne, Oakland and Macomb to correspond to the 1970 Census Bureau's Standard Metropolitan Statistical Area. The Survey has received the endorsement of the Medical and Osteopathic Societies of Wayne, Oakland and Macomb, and is being carried out in cooperation with the Michigan State Department of Health. The hospitals in the survey areas were contacted individually and their cooperation was sought and obtained.

Objectives and Plans

The principle objective of the survey is to obtain information concerning the incidence and the prevalence of the various kinds of cancer. The information being collected related to (1) demography, e.g., age, sex, marital status, (2) pathology, e.g., site and histologic type of the cancer, (3) methods of diagnosis and treatment. Information concerning the social and economic impact of cancer is also being collected by interviewing 10 percent of the cancer patients or members of their families.

In planning the 1969-71 survey, procedures were devised to achieve complete cancer case finding. To a large measure the success of the survey is directly related to our ability to identify each new case of cancer which occurs in the Detroit metropolitan area during the three years of the survey. These procedures are as simple and efficient as possible, in order to minimize the effort which will be required of physicians and hospital staffs. However, the worth of the 1969-71 survey will be determined finally by the level of interest and assistance provided by the physicians and hospitals surveyed.

Besides providing current demographic and epidemiologic information concerning cancer that will be useful to physicians and others concerned with the care of cancer patients, the survey findings will be valuable to them in planning treatment and care facilities. The information collected will be available to the Michigan State Medical Society, the Michigan Hospital Association and others charged with the responsibility for organizing and planning for medical care in our state.

Implementation

The Michigan Cancer Foundation through its Registry Division, assists hospital cancer programs with the collection, storage, retrieval, analysis and interpretation of cancer patient information. The Central Registry assists hospitals in the organization and development of cancer programs.

The Third National Cancer Survey in the Detroit Metropolitan area has been implemented by the Michigan Cancer Foundation. A contract has been negotiated with the National Cancer Institute outlining the conditions for the survey, and providing fiscal support. The Registry Division staff has been expanded to assist in the collection and preliminary processing of the cancer information.

(Continued on Page 944)

Michael J. Brennan, M.D., in addition to acting as Project Director is President of the Michigan Cancer Foundation and Professor of Medicine at W.S.U. School of Medicine. James F. Groen, M.A., is Director of the Registry Division, Michigan Cancer Foundation.

When you choose a tetracycline...

Your first concern: Integrity of product.

Effectiveness: ACHROMYCIN Tetracycline is a crystalline broad-spectrum antibiotic which provides effective therapeutic activity against susceptible microorganisms.

Contraindication: History of hypersensitivity to tetracycline.

Warning: In renal impairment, usual doses may lead to excessive accumulation and liver toxicity. Under such conditions, lower than usual doses are indicated and, if therapy is prolonged, serum level determinations may be advisable. Some patients may develop a photodynamic reaction to natural or artificial sunlight. Those with a history of photosensitivity reactions should avoid direct exposure to sunlight while under treatment. Discontinue drug at first evidence of skin discomfort.

Precautions: Use may result in overgrowth of nonsusceptible organisms. Constant observation is essential. If new infections appear, take appropriate measures. Use of tetracycline during teeth development may cause discoloration of teeth.

Side Effects: Gastrointestinal system—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. Skin—maculopapular and erythematous rashes (a case of exfoliative dermatitis has been reported); photosensitivity reaction, onycholysis and discoloration of nails (rare). Kidney—rise in BUN, apparently dose-related. Hypersensitivity reactions—urticaria, angioneurotic edema, anaphylaxis. In young infants, bulging fontanels have been reported following full therapeutic dosage. This symptom has dis-

Your second concern:
~~Cost to the patient.~~

Scratch the second
because Achromycin V Capsules
now priced at "generic" levels!

Now you can feel as comfortable about its cost as you always have about its quality.

Achromycin® V capsules Tetracycline HCl

appeared rapidly when drug is discontinued. Teeth—dental staining (yellow-brown) in children of mothers given tetracycline during the latter half of pregnancy, and in children given the drug during the neonatal period, infancy and early childhood. Enamel hypoplasia has been seen in a few children. Blood—anemia, thrombocytopenic purpura, neutropenia, eosinophilia. Liver—cholestasis (rare), usually at high dosage. Tetracycline may form a stable calcium complex in bone-forming tissue. If adverse reaction or idiosyncrasy occurs, discontinue medication and institute appropriate therapy.

Average Adult Daily Dosage: One Gm. per day, in 4 divided doses of 250 mg. each. Should be given 1 hour before or 2 hours after meals, since absorption is impaired by the concomitant administration of high calcium content drugs, foods and some dairy products. Treatment of streptococcal infections should continue for 10 days, even though symptoms have subsided.

Lederle

LEDERLE LABORATORIES
A Division of
American Cyanamid Company
Pearl River, New York 10965

298—0

Collection Of Hospital Cancer Data

Presently 85 Michigan hospitals are actively participating in the program, and are developing cancer programs or are organizing them. More than 75 per cent of the new cancer patients in the Detroit area are admitted to the hospitals which participate in the Registry Division's program. Since the data required for the survey are substantially the same as those already being collected by hospitals participating in the Central Registry, no significant changes will be required in the procedures presently used for collecting their data.

The legality of the transmission of medical information from local hospitals to the Registry Division has been established by state statute in 1957. All the medical information obtained will be treated as confidential. A copy of the statute will be provided to any physician or hospital requesting it.

Collection Of Physician Cancer Data

All of the physicians in the survey area have been requested to participate in the survey in two ways. First, each physician is asked to complete a short report of cancer patients seen in his office. Over 8,000 physicians are sending these reports to the survey offices periodically. Second, if a cancer patient is selected for interview to obtain social, economic and cultural data, the patient's physician is contacted and requested to permit his patient to be interviewed. If the physician agrees, the patient is then contacted and an interview is requested. During the interview, which is conducted in the patient's home, every effort is made to insure privacy and confidentiality. The patient may terminate the interview at any time. Interviewers do not discuss medical aspects of a patient's case with him or his family. The content of the interview does not inform the patient that he has cancer and the interview office is identified only as the "Statistical Health Survey" so that confidentiality can be maintained.

Death Certificate Data

The Michigan Center for Health Statistics provides microfilm copies of all cancer deaths in the three county areas to insure all cancer cases are surveyed. The procedures developed for processing the data in the Registry Division include maintaining a master file of all new cases of cancer as they are identified or found during the course of the survey. After it has been determined that a patient with cancer reported by a hospital, a physician or the Center for Health Statistics, is a new case his record is added to the master file. Procedures to eliminate duplication in the reporting of medical information about patients entail many cross checks. For example, the cases reported by physicians will be checked against the file of patients reported by hospitals. Physicians will be asked to provide medical information *only* for those patients for whom no information has been obtained from a hospital. Correlation of the hospital patient file against the master file eliminated the possibility of duplication when a patient has been hospitalized in two or more hospitals.

The preliminary editing and coding of the cancer data is being done at the Registry Division of the Michigan Cancer Foundation. It will retain custody of the original records at the close of the survey. At the National Cancer Institute, the editing and coding of the data is completed, and the information transferred to magnetic tape for computer analysis.

Summary

The Third National Cancer Survey in the Detroit area has been described. It is being performed by the Michigan Cancer Foundation, Registry Division and involves all the hospitals and physicians in the metropolitan Detroit area and the Center for Health Statistics at Lansing. In order to achieve the primary objective of the survey the assembling of accurate information concerning the incidence and prevalence of cancer in the Detroit Metropolitan Area — it will be necessary to identify every new case of cancer occurring during the years 1969-71. The procedures described were designated with this objective in mind and with the purpose of minimizing the amount of effort that hospital personnel and physicians will need to expend

The Third National Cancer Survey will provide an opportunity for hospitals and physicians to demonstrate again their capability and willingness to make essential contributions to our understanding of cancer and its treatment.

Surrounded by majestic mountains, Hong Kong harbor is alive with the hustle and excitement of international activity. The October MSMS Orient Adventure will bring Michigan physicians and their wives here for seven days, and allow for side trips including Bangkok, Thailand.

Medical technology is demanding enough--

Here's how to relieve the demands of business:

— and enjoy personal satisfaction, peace of mind nd freedom of time greater than you may have magined possible.

Just a few years ago, a group of doctors in Kentucky resolved to make their practices simpler nd more profitable. They formed a non-profit corporation, the Professional Service Corporation Association. The doctors talked with many professional consultants. Together they explored every spect of practice — office procedure, billing, accounting, salaries, fringe benefits, insurance, retirement, equipment — even auto leasing — literally every business demand. Time and energy were avished on every detail. Each was honed, polished nd perfected. Now, benefits in each of these reas are available to PSCA members.

Specific business guidelines are the key

You may unknowingly be using business techniques discarded years ago by professional businessmen. You may be needlessly hampered by restrictions — penalized by advice from persons not knowledgble in medicine. Today, PSCA guidelines for systematic and simplified business procedures can be pplied to incorporated practices. Remarkable benefits are immediately available.

Get every benefit you're entitled to

Professional Service Corporation Association (PSCA) offers members complete guidance to qualify for very benefit legitimately available. You'll find this list surprisingly long. Exceptional financial rewards are possible. Details of planned incentives and benefits for employees are covered. Carefully qualified and professional services are made available exclusively to PSCA members.

Direct and immediate cash savings — three and four times your membership fee — may be realized in a single business transaction.

Here's how you can get these remarkable benefits

Regular PSCA membership is open to incorporated professionals exclusively. Junior membership to qualified senior students, interns, residents and fellows. Dues for Regular membership are $25 for each stockholder-employee per year. $10 for Junior members. Complete the coupon below and send it with your check today. You'll be provisionally enrolled until qualification is approved. Benefits of membership come just as easily as this means of joining. Full information covering all details will start you enjoying your chosen profession as never before.

To PSCA: Enroll me as a ☐ Regular ☐ Junior member for one year. My practice specialty is________________.
Send full information and details to:

NAME____________________

TITLE____________________

CORPORATE NAME________________

ADDRESS____________________

CITY__________ STATE______ ZIP______

(Your fee is refundable if you do not qualify.)

Professional Service Corporation Association, Inc.
A non-profit organization formed and controlled by doctors
622 Commonwealth Building, Louisville, Ky. 40202
Phone: 502/583-8164

editorial viewpoints

The Role Of Intern, Resident On Health Care Team

By Jason Bodzin, M.D.
Associate Scientific Editor

Recently there has been considerable dialogue concerning the delivery of health care and the concept of the health care team. The latter concept envisions the use of paramedical and ancillary health workers. Little has been said concerning the relationship of the interns and residents (house staff) in the total concept of the health care team.

What is the purpose of a graduate training program at the internship and residency level? Is it a rote exercise in which the house staff member is a passive individual who only carries out others' bidding? Or, should it be a learning process where the individual is made to think, formulate decisions and follow them through, i.e., to become an active, participating member of this so-called health care team?

Such a team approach is a two-edged sword. It first assumes that the house staff member is aggressive, knowledgeable, well-read in the basic current literature and willing to take the time and effort to follow through on logical conclusions. He must be willing to spend time in the continuing care of the hospitalized patient. He must make the personal effort to get the most out of his attending staff (this may be difficult for the house staff member).

On the other edge of this sword are the requirements and responsibilities imposed upon the attending man in the teaching hospital. He must be willing to abrogate some of his self-felt authoritarianism; he should be willing to give over to the house staff some of the decision making in the care of his patients (this does not mean abandonment of his patients — the attending physician still acts as mentor, advisor and prodder to the house staff in the latter's decision making). The attending staff must be willing to give the house staff the necessary time to assist them in the learning process. And this includes time to listen to the house staff's viewpoints in patient care.

In all institutions there are men who are capable and willing to teach. There are also men who for various reasons either do not have the time or capability to teach (this is no slur on their medical knowledge or patient care abilities). Since the graduate training period is one of limited duration and increasing complexity, would it not be better for the house staff to have their greatest exposure to those attending who have the greatest desire and ability to teach? In some hospitals this would mean a rearrangement of not only the mechanism of the teaching program, but also some rearrangement of the administrative program, e.g., arrangements for admitting patients to geographical areas utilized by this portion of the staff.

If the training hospital feels that this concept of team effort (attending staff — house staff) leads to better patient care, then it must not only foster this relationship but it must also endeavor to provide an internal structure that will accommodate the educational process in its highest degree.

Doctor, Your Wife Should Belong To Woman's Auxiliary

By Mrs. Francis P. Rhoades
President
Woman's Auxiliary to MSMS

Because the medical auxiliary provides her with opportunities for self-growth, meaningful activities in her husband's profession, and provides a common meeting ground with the wives of other physicians, the physician's wife should belong to the auxiliary.

As Dwight Wilbur, M.D., past-president of the AMA said, "We physicians turn to the auxiliary for help in serving as a liaison between the profession and the public."

It is becoming increasingly necessary for physicians' wives to belong to the auxiliary. With the medical profession experiencing almost catastrophic pressure from government, labor, industry, and insurance carriers, the private practice of medicine that has been traditional in this country, is being assailed as inefficient and too costly.

As physicians' wives we are well aware of the long hours our husbands work, and the amount of constant postgraduate education needed to keep abreast of advances in medical and scientific development. Through collateral organizations, church, and service groups we can defend medical practice more effectively, and present to the public the true value of our present methods of rendering comprehensive medical care to everyone.

As members of the auxiliary we stand ready to assist the medical society in many fields. We have at our disposal comprehensive material to assist in community-wide programs on alcoholism, durg abuse, homemaker services, sex education, mental health, V D education, immunization, as well as coordinated programs of community health education and safety, health manpower recruitment, and fund-raising projects for health career scholarships.

Do the members of the medical society really know about their auxiliary's accomplishments in their behalf? If they do, they might encourage their wives to join and participate in its many health-oriented activities. Auxiliary membership demonstrates to the medical and civic community that the doctor's wife is accepted and welcomed by the medical profession as a full partner in the cause of better health for all people.

Doctor, does your wife belong? If not, don't you think she should?

The First Twenty Years

By Marlouise K. Redman
Speaker of the House
Michigan State Medical Assistants Society

The Michigan State Medical Assistants Society is sponsored by the Michigan State Medical Society, and is an outgrowth of the Detroit Medical Assistants Society which was founded in October, 1940 for the promotion of knowledge relating to medical assistants.

A Medical Assistants Conference was held in conjunction with the Michigan State Medical Society Annual Meeting in 1941 and much interest was stimulated toward organizing a state society. World War II intervened and cancelled all further meetings until 1948 when a desire to organize a statewide society was again expressed.

On September 22, 1949 the Michigan State Medical Assistants Society was organized and a constitution and by-laws was adopted. Within the first year, Allegan, Bay, Detroit, Ingham, Kalamazoo, Kent, Ottawa and Saginaw became component societies. The first annual meeting was held in 1950 with a total membership of 203 members. The first *Bulletin* was published in April 1950 and the society selected a pin to be worn by its members.

In 1951 representatives were sent to the County Secretaries and Public Relations Conference of the Michigan State Medical Society and since that time representatives have been invited to all functions of the Medical Society. Since 1954 our president has represented the society before the House of Delegates of the Medical Society.

The Medical Assistants of Michigan have sponsored County Officers and Committee Chairmen Workshops, Annual Educational Seminars and Medical Assistants In-Service Training Programs, which became a reality when classes began in February 1958 in three pilot study areas.

Michigan was in attendance at the first organizational meeting for a national medical assistants society, and has been well represented on the Board of Directors and Committees of the American Association of Medical Assistants since Nov. 5, 1955. In 1962 the Annual Convention was held in Detroit, Michigan.

At our Fifteenth Annual Meeting in September 1964, the first House of Delegates was held and in 1965 our first Certified Medical Assistant was introduced.

During April of 1970 the Michigan State Medical Assistants Society held its Twentieth Annual Meeting with Delegates from 22 component societies.

PLAINWELL SANITARIUM, INC.

Plainwell, Michigan

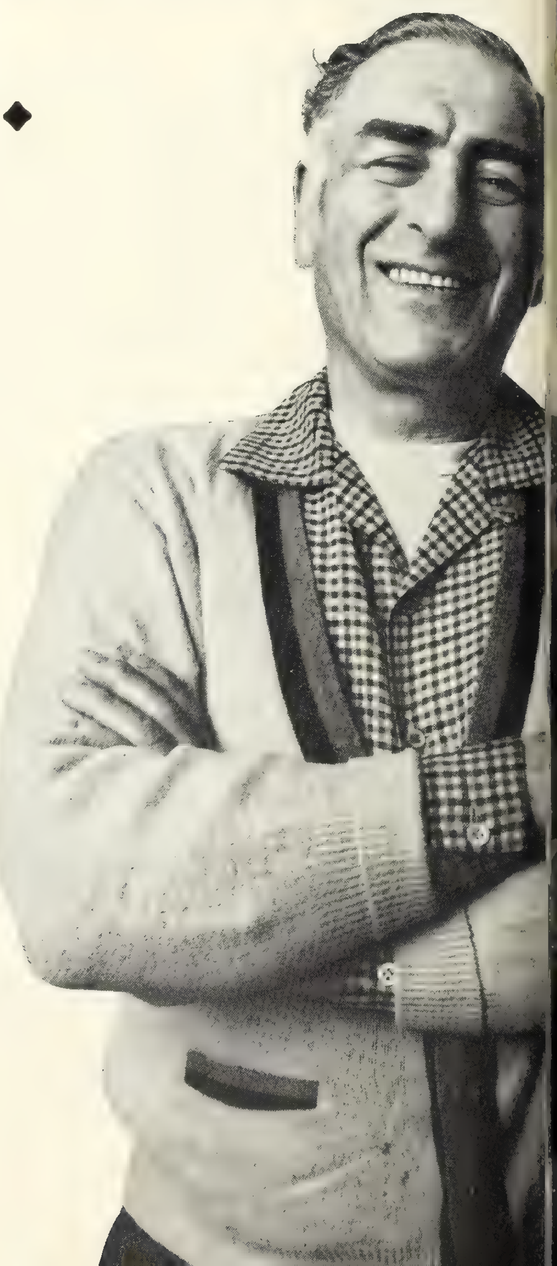
M. Leroy Barry, MD
D. W. Everett, MD
W. R. King, PhD

The Plainwell Sanitarium is a private psychiatric hospital licensed by the Michigan Department of Mental Health and accredited by the Joint Commission on Accreditation of Hospitals. Our extensive diagnostic and treatment services include the following:

- Organic and psychological therapy for the psychiatrically and emotionally disturbed of all ages.
- Diagnostic and psychological evaluation and hospitalization, if indicated, of juveniles for courts and social agencies.
- Rehabilitative services for geriatric and convalescent patients.
- Medico-legal counsel.
- Out-patient services.

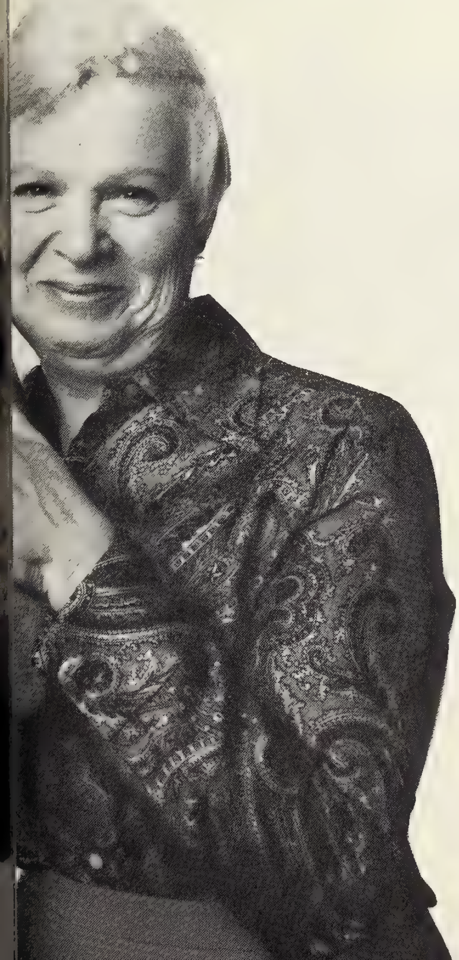
685-8441 Admissions
685-5952 Out-patients

Menrium® treats the menopausal symptoms that bother him most.



Roche

His wife has a lot of different
enopausal symptoms, but only a few
ally irritate *him*. Her hot flashes, her
ertigo, her palpitations—that's *her*
roblem. What really bothers him is
er nervousness, her irritability and
er excessive anxiety, often expressed
y endless "book-shuffling, chain-
noking, reading-lamp" insomnia!
Menrium takes care of hot flashes,
ertigo, palpitations in most
enopausal women. Menrium
rovides the well-known antianxiety
ction of chlordiazepoxide (Librium®)
nd water-soluble esterified estrogens.
therefore relieves more symptoms
an either component separately.
takes care of the vasomotor
mptoms as well as the emotional
mptoms. This means the symptoms
at bother his wife most. And the
mptoms that irritate him most.
So, to help them both get through
r menopause, remember Menrium.



Before prescribing, please consult complete product information, a summary of which follows:

Indications: Management of manifestations generally associated with the menopausal syndrome—anxiety and tension, vasomotor complaints and hormonal deficiency states.

Contraindications: Women with cancer of breast or genitalia, except inoperable cases, and those with known hypersensitivity to chlordiazepoxide and/or esterified estrogens.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Exclude other possible causes of menopausal syndrome manifestations, such as pregnancy. Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions) similar to those seen with barbiturates have been reported following discontinuance of chlordiazepoxide HCl. Potential benefits of use in pregnancy, lactation or women of childbearing age should be weighed against possible hazards to mother and child. Clinical data inadequate on safety in pregnancy.

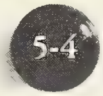
Precautions: In elderly and debilitated patients, limit dosage to smallest effective amount of chlordiazepoxide (initially 10 mg or less per day) to preclude ataxia or oversedation; increase gradually as needed and tolerated. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects—particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in patients with impaired renal or hepatic function. Paradoxical reactions to chlordiazepoxide (*e.g.*, excitement, stimulation and acute rage) have been reported in psychiatric patients. Employ usual precautions in the treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation very rarely reported in patients receiving Librium® (chlordiazepoxide) and oral anticoagulants.

Adverse Reactions: Untoward effects seen with either compound alone may occur with Menrium. With chlordiazepoxide, drowsiness, ataxia and confusion reported in some patients, particularly in the elderly and debilitated; while usually avoided by proper dosage adjustment, these are occasionally observed at lower dosage ranges. Also reported have been a few instances of syncope; isolated occurrences of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido, and occasional reports of blood dyscrasias, including agranulocytosis, jaundice and hepatic dysfunction. Periodic blood counts and liver function tests advisable during protracted treatment. Changes in EEG patterns (low-voltage fast activity) observed during and after chlordiazepoxide treatment.

With estrogens, headache, nausea and vomiting, anorexia, gastrointestinal discomfort, dysuria and urinary frequency, jitteriness, breast engorgement, formation of breast cysts, skin rashes and pruritus occasionally seen. Administration may also be associated with uterine bleeding and/or followed by withdrawal bleeding.

Usual Dosage: One tablet t.i.d. for 21 days, followed by one-week rest periods.

Menrium® T.I.D.

5 mg chlordiazepoxide		**0.2 mg water-soluble esterified estrogens**
5 mg chlordiazepoxide		**0.4 mg water-soluble esterified estrogens**
10 mg chlordiazepoxide		**0.4 mg water-soluble esterified estrogens**

ancillary

WSU Med Students Begin New Program In Community Medicine

Emphasizing the urban, disadvantaged patient as a consumer of medical care, an innovative Wayne State University program was launched Aug. 3 to give WSU medical students a better understanding of health care in the United States.

Director of the new program in community medicine is Ruben Meyer, M.D., professor of pediatrics and a member of the WSU School of Medicine since 1942.

As part of the third year curriculum, junior medical students are working full-time in a Detroit health care facility for a period of 5½ weeks to gain on-the-job insight on:

- Health manpower, including alternative methods of delivering health care and roles for new health workers
- Complexities of the varying approaches to organizing, and financing health care services, and the impact of various approaches on the accessibility, comprehensiveness, continuity and quality of service provided.

Professionals in these health care facilities are serving as field instructors, with appointment to the adjunct faculty of the medical school. Other faculty for the multi-disciplinary team are drawn from the various health schools and behavioral sciences of Wayne State University, including its College of Nursing, College of Pharmacy, School of Social Work and School of Medicine.

The student experience with the health care agency is supported by weekly seminars at the medical school on subjects such as:

- Medical care for the indigent, National health insurance: pros and cons, Roles of the consumer in the health care systems, or Financing health care.

One evening program is offered during every 5½ week period. Open to all students and faculty at the University, this meeting provides a forum for nationally recognized authorities in the field of health care. First speaker for this series was James G. Haughton, M.D., First Deputy Administrator for the Health Services Administration of New York City. He discussed "Organization of Community Health Services for Urban Populations."

A four-year commitment from the W. K. Kellogg Foundation was begun this year to enable Wayne State University to design and implement programs for the improvement of the delivery of medical services in metropolitan areas. The Kellogg award, totaling $450,800, calls for $128,800 to be provided during each of the first three years, and $64,000 during the fourth year.

Symposium On Reproduction Oct. 29 - 30 at WSU

More than 300 obstetricians and gynecologists are expected to attend the Harold C. Mack Symposium on Physiology and Pathology of Reproduction Oct. 29-30 at the Rackham Building, Detroit. The two-day meeting is sponsored by the Department of Gynecology and Obstetrics at the Wayne State University School of Medicine, and by Harper Hospital.

"Biology of Fertilization and Implantation" is the theme.

Chairman of the Program Committee is Kamran S. Moghissi, M.D., Professor of Gynecology and Obstetrics at WSU.

Michigan Regional Drug Information Center Expands

The Michigan Regional Drug Information Center at the University of Michigan Medical Center has been serving Michigan physicians for over two years. In that time, it has processed over 4,300 questions from more than 620 physicians wishing information on the identification, availability and side effects of the nation's drugs.

The center has expanded its services during its second year by opening new branches at Blodgett Memorial Hospital, Grand Rapids; Saginaw General Hospital; St. Lawrence Hospital, Lansing; Mercy Hospital, Bay City; Hurley Hospital, Flint; Bronson Hospital, Kalamazoo; Bectel Pharmacy, Muskegon, and the WSU College of Pharmacy-Detroit General Hospital.

MSU Developing Postgraduate Medical Education

The September issue of MICHIGAN MEDICINE carried a list of postgraduate medical education courses planned during 1970-71 at the University of Michigan Medical Center.

This issue contains a list of postgraduate medical courses scheduled during the first quarter of the 1970-71 school year by the Wayne State University School of Medicine (next page), and a statement of the concept of postgraduate medical education held by the College of Human Medicine at Michigan State University (immediately following).

By David S. Greenbaum, M.D.
Continuing Medical Education
College of Human Medicine
Michigan State University

The College of Human Medicine, Michigan State University, has a commitment and a vested interest in Continuing Medical Education. Educational research suggests that the practicing physician learns best:

1. when he has a role in the program planning;
2. when the topics are closely related to the physician's educational needs, as variously defined;
3. when the program is conducted on an ongoing basis;
4. when the program is conducted in the environment in which he works;
5. when there is periodic assessment of the participant's progress in the program so that he may know his weak and strong points;
6. when the program is frequently re-evaluated and, if necessary, changed to best meet the physician's requirement; and
7. when there is flexibility of the instructional methods depending on the topic and circumstances (i.e., self-teaching units, "handouts," literature references, lectures, seminars, and workshops with utilization of audiovisual aids where appropriate) with encouragement of active participation of the physician.

Accordingly, a long-range program, stressing these aspects, is being developed. It is hoped that many of the programs will probably be in local communities in response to medical educational needs. Various well-developed services of the University are to be used to facilitate this approach.

MICHIGAN
STATE
MEDICAL
SOCIETY

NEW MSMS MEMBERSHIP

MSMS now has available a gold-filled Official MSMS Membership Pin for use in the coat lapel, as a tie tack, etc. Send check made out to MSMS for $3.00 to Michigan State Medical Society, 120 West Saginaw, East Lansing, Michigan 48823.

Kellogg Grant To Aid U-M In Patient Unit Study

The University of Michigan's Bureau of Hospital Administration in the School of Public Health has been awarded a $120,500 grant by the W. K. Kellogg Foundation of Battle Creek for a two-year study of the management of patient units in hospitals. The research will be conducted in several large hospitals selected for their innovations in management.

New Drug Developed To Treat Alcoholics

A new tranquilizer for the treatment of alcohol dependence, Serentil® (mesoridazine), has been made available by Sandoz Pharmaceuticals.

In developing Serentil, Sandoz supported the Center of Alcohol Studies, Rutgers University, in a massive statistical survey of alcohol dependence and physicians' attitudes toward the problem, including a state-by-state analysis. From the survey and other data it was shown, for example, that while Michigan ranks sixth in the total number of alcoholics, it ranks 11th in per capita number. It was also noted that fewer Michigan physicians (compared with the national average) report that at least half their problem drinkers are women.

Postgraduate Courses At WSU School of Medicine

First Quarter
Wayne State University
1970-1971
School of Medicine

COURSE	DAY	TIME	DATE	FEE	PLACE
ANESTHESIOLOGY					
Postgraduate Program in Anesthesia	Mon.	3:30 to 5:00 p.m.	11-9-70 to 3-29-71	$75.00 $50.00 residents	Detroit General Hospital, 4th Floor Auditorium
DERMATOLOGY					
Histopathology of the Skin I	Wed.	1:15 to 4:15 p.m.	9-23-70 to 12-16-70	$60.00	Detroit General Hospital, 4th Floor Auditorium
INTERNAL MEDICINE					
Electrocardiography I	Wed.	5:00 to 6:00 p.m.	10-7-70 to 12-16-70	$33.00	Lafayette Clinic Auditorium
OCCUPATIONAL AND ENVIRONMENTAL HEALTH					
0502 Principles of Industrial Hygiene	Thurs.	3:00 to 5:00 p.m.	10-1-70 to 12-17-70	$60.00	625 Mullett, Room 105.1
0502 Principles of Industrial Hygiene	Mon.	5:00 to 7:00 p.m.	10-5-70 to 12-14-70	$60.00	625 Mullett, Room 105.1
0710 Principles of Industrial Toxicology	Tues.	3:00 to 5:00 p.m.	10-6-70 to 12-15-70	$90.00	625 Mullett, Room 105.1
0760 Industrial Ventilation	Wed.	3:00 to 5:00 p.m.	10-7-70 to 12-16-70	$90.00	625 Mullett, Room 105.1
OPHTHALMOLOGY					
Basic Sciences of Ophthalmology	Mon. thru Sat.	8:00 to 12 Noon	9-14-70 to 5-31-71	$300.00	Kresge Eye Institute of Wayne State University
PATHOLOGY					
Neuropathology	Mon.	1:30 to 3:00 p.m.	10-5-70 to 12-21-70	$66.00	Harper Hospital, 7th Floor
Neuropathology	Tues.	1:00 to 3:00 p.m.	10-6-70 to 12-22-70	$66.00	School of Medicine, Room 307
Hematology	Wed.	1:30 to 3:30 p.m.	10-7-70 to 12-23-70	$66.00	Veterans Administration Hospital
Cytology	Fri.	1:30 to 3:30 p.m.	10-2-70 to 12-18-70	$66.00	Veterans Administration Hospital
PHYSIOLOGY-PHARMACOLOGY					
0764 Cellular Physiology	Arr.	Arr.	10-1-70 to 12-20-70	$60.00	Wayne State University, School of Medicine
PSYCHIATRY					
Psychiatric Concepts of Medical Practice	Wed.	11:00 to 12:30 p.m.	10-7-70 to 6-9-71	$60.00	Grace Hospital, Northwest Branch, 18700 Meyers Road
RADIOLOGY					
Fundamentals of Radiologic Physics	Tues., Wed.	4:30 to 6:00 p.m.	9-29-70 to 12-23-70	$66.00	Detroit General Hospital, 4th Floor Auditorium
Roentgenology Diagnostic Seminar	Thurs.	5:00 to 6:00 p.m.	9-124-70 to 12-17-70	$33.00	Detroit General Hospital, 4th Floor Auditorium
H. C. Mack Symposium	Thurs., Fri.	8:00 a.m.	10-29-70 and 10-30-70	$75.00	Rackham Memorial Building

The Wayne State University School of Medicine regularly schedules conferences and seminars to which interested individuals in the health sciences are invited without fee. Most are scheduled for one hour, one day per week. This fall the short, daytime meetings are planned under the general topics of biochemistry, community medicine, general surgery, gynecology-obstetrics, internal medicine, neurology, neurosurgery, occupational and environmental health, oncology and psychiatry.

in memoriam

Marion E. Bovee, M.D.
Lexington

Marion E. Bovee, M.D., Port Huron area physician for 51 years, died Aug. 9 at the age of 81. Doctor Bovee was in active general practice until his death.

He was a life member of the St. Clair County and Michigan State Medical Society and was graduated from the Detroit College of Medicine. He first practiced in Maple Ridge.

John M. Carter, M.D.
Fort Lauderdale

John M. Carter, M.D., a Detroit otolarynologist for 40 years, died July 11 at the age of 80. He had retired to Fort Lauderdale in 1963.

Doctor Carter was a graduate of Johns Hopkins University and was a member of the American Academy of Ophthalmology and Otolaryngology and the American College of Surgeons.

Gordon M. Finnie, M.D.
Hastings

Gordon McKnight Finnie, M.D., Hastings surgeon since 1963, died July 15 at the age of 38. He had Hodgkin's Disease.

Doctor Finnie was a graduate of the University of Michigan Medical School and was a fellow of the American College of Surgeons. He was affiliated with Blodgett Memorial Hospital, Grand Rapids, and was a member of the Michigan Association of the Professions. He was chief of the surgical staff at Pennock Hospital in Hastings for several years.

Charles T. Foo, M.D.
Bradenton, Fla.

Charles T. Foo, M.D., long-time St. Johns general practitioner, died July 16 in Bradenton, Fla., where he retired 13 years ago.

Doctor Foo was a graduate of the Detroit College of Medicine and Surgery and had been affiliated with Clinton Memorial Hospital in St. Johns. He was a past president of the Clinton County Medical Society.

Established 1924

MERCYWOOD HOSPITAL

4038 Jackson Road
Conducted by Sisters of Mercy
Ann Arbor, Michigan
Telephone — 313 663-8571

Mercywood Hospital is a private neuropsychiatric hospital licensed by the Michigan Department of Mental Health. Mercywood specializes in intensive, multi-disciplinary treatment for emotional and mental disorders.

Accredited by the Joint Commission on Accreditation of Hospitals and the National League of Nursing. A full Blue Cross participating hospital.

Certified for: Medicare and M.A.A. programs

PSYCHIATRIC STAFF

Lyle M. Allis, M.D.
Robert J. Bahra, M.D.
Dean P. Carron, M.D.
Francis M. Daignault, M.D.
Gordon C. Dieterich, M.D.
James R. Driver, M.D.
Robert L. Fransway, M.D.
Stuart M. Gould, Jr., M.D.
Leonard E. Himler, M.D.*
Sydney Joseph, M.D.
Hubert Miller, M.D.
Jacob J. Miller, M.D.
Rudolf Nobel, M.D.
Gerard M. Schmit, M.D.
Richard D. Watkins, M.D.

*1904-1967

Victor Glickman, M.D.
Detroit

Victor Glickman, M.D., Detroit psychiatrist, died in July at the age of 50.

Doctor Glickman was born in Russia and was graduated from the Ygotouto University School of Medicine in Lithuania. He served as a medical officer in Germany from 1945-47 and then entered the study of psychiatry. He had been affiliated with Pontiac State Hospital and at the time of his death was engaged in private practice in Detroit.

William E. Henderson, M.D.
Harper Woods

William Ewart Henderson, M.D., chief of staff at Detroit Memorial Hospital, died Aug. 20 at the age of 80. He was in active practice at the time of his death.

Doctor Henderson was a founder and member of the board of trustees at Detroit Memorial. He was graduated from Wayne State University School of Medicine and also held a degree in pharmacy from WSU.

Doctor Henderson was honored in 1963 by the WSU Pharmacy Alumni Association for 50 years of service to the profession. He has two sons who are Michigan physicians.

Aniello Infante, M.D.
Saginaw

Aniello Infante, M.D., Saginaw physician since 1963, died July 20 in an automobile accident. He was 42.

Doctor Infante was a graduate of the University of Naples, Italy, Medical School, and was a general practitioner. He was affiliated with St. Mary's, St. Luke's and Saginaw General Hospitals in Saginaw. He came to the United States from Italy in 1958.

Willard R. Klunzinger, M.D.
Lansing

Willard R. Klunzinger, Lansing ophthalmologist, died Aug. 16 at the age of 55.

Doctor Klunzinger was graduated from the University of Michigan Medical School and was affiliated with E. W. Sparrow and St. Lawrence Hospitals in Lansing.

He was a past secretary and treasurer of the Michigan Triological Society and belonged to the American Academy of Ophthalmology and Otolaryngology. He also was a member of the Flying Physicians.

Abraham D. Litsky, M.D.
Detroit

Abraham D. Litsky, M.D., Detroit surgeon for 39 years, died July 29 at the age of 66.

Doctor Litsky was a member of the American Geriatric Society and was affiliated with Holy Cross and Lakeside General Hospitals in Detroit. He was graduated from the University of Michigan Medical School.

J. H. McMillin, M.D.
Monroe

John Harold McMillin, M.D., Monroe otolaryngologist for 25 years until his retirement last year, died July 6 at the age of 74.

Doctor McMillin was a former member of the Radio Committee of the Michigan State Medical Society and also belonged to the Michigan Triologic Society and Pan-American Society of Ophthalmology.

He was affiliated with Monroe Hospital, where he was chief of staff for many years, and was graduated from the University of Nebraska College of Medicine. He first practiced in Dundee.

Edward R. Nell, M.D.
Laguna Beach, Calif.

Edward R. Nell, M.D., former Kalamazoo physician until moving to Laguna Beach in 1955, died July 4 at the age of 61. He practiced medicine and surgery in Kalamazoo until entering the service in 1941. He moved to Laguna Beach in 1955.

Doctor Nell, a graduate of the University of Michigan Medical School, was one of the survivors of the "Death March" on Bataan during World War II, won several service citations including the Silver Star, was a Japanese prisoner of war and was among the war crime trial witnesses at Yokohama, Japan.

Charles E. Parkinson, M.D.
Battle Creek

Charles Eugene Parkinson, M.D., Battle Creek radiologist, died July 3 at the age of 54.

Doctor Parkinson received his M.D. degree in

New Film Available On Postmenopausal Woman

Ayerst Laboratories now offers a new medical film about estrogen replacement therapy, called "The Long Range Problems of the Postmenopausal Woman." Suggested for medical groups, the film is 43 minutes, color and sound. To obtain the film, write to John B. Jewell, M.D., Medical Department, Ayerst Laboratories, 685 Third Ave., New York, N.Y., 10017.

1949 from the University of St. Louis and had earlier been a teacher, Olivet College professor and captain in the Army. He served as an Air Force captain from 1950 to 1952 and served on the hospital ship S.S. Hope in 1964 in the waters of Peru and Ecuador.

Doctor Parkinson was a past secretary, editor and program chairman of the Calhoun County Medical Society and had been affiliated with the Leila Y. Post Montgomery Hospital in Battle Creek.

Oliver C. Pratz, M.D.
Flint

Oliver Charles Pratz, M.D., Flint general practitioner since 1933, died July 29 at the age of 74.

Doctor Pratz was a former surgeon-general of the national Veterans of Foreign Wars and had been affiliated with Hurley, St. Joseph's and McLaren General hospitals in Flint.

Anthony G. Sack, Sr., M.D.
Southfield

Anthony George Sack, M.D., Southfield general practitioner, died Aug. 15 at the age of 69.

Doctor Sack was a graduate of the University of Michigan Medical School. He was a member of the staff of Providence Hospital for 43 years, serving as chief of staff in 1959.

Donald C. Swan, M.D.
Birmingham

Donald Charles Swan, M.D., Birmingham obstetrician and gynecologist, died Aug. 17 at the age of 39.

Doctor Swan was graduated from the University of Western Ontario medical school and had been practicing two years in the Detroit area. He was a member of the American College of Obstetrics and was affiliated with Sinai and Crittenton General Hospitals of Detroit.

The advertising in
MICHIGAN MEDICINE
keeps you informed
and helps pay the
publishing costs.

When the local
representative calls, Doctor,
tell him you saw
his company's ad
in your journal.

The treatment of **impotence** in the American male is complex. The concept of chemotherapy plus the physician's psychological support is confirmed as effective therapy.

NEW CLINICAL STUDY

The Treatment of Impotence
with Methyltestosterone Thyroid
(100 patients — Double Blind Study)
T. Jakobovits
Fertility and Sterility, January 1970
Official Journal of the
American Fertility Society

Android®
(thyroid-androgen) tablets

Double-Blind Study and Type of Patient: 100 patients suffering from undifferentiated impotence. Examination revealed the patients were within the average range of 17-Keto-steroid excretion and protein bound iodine. Except for fatigue in some patients all were in good health. Study was for one month in duration. Each patient received one tablet 3 times daily.

Results: Of the patients receiving the active medication (Android) a favourable response was seen in 78%. This compares with 40% with those on placebo. 80% of the patients treated with the active ingredients showed relief in fatigue compared with 42% of those receiving the placebo. Although psychotherapy is indicated in patients suffering from functional impotence the concomitant role of chemotherapy (Android) cannot be disputed.

Choice of 4 strengths:

Android

Each yellow tablet contains:

ethyl Testosterone	2.5 mg.
hyroid Ext. (1/6 gr.)	10 mg.
lutamic Acid	50 mg.
hiamine HCL	10 mg.

ose: 1 tablet 3 times daily.
vailable:
ottles of 100, 500, 1000.

Android-HP
HIGH POTENCY

Each red tablet contains:

Methyl Testosterone	5.0 mg.
Thyroid Ext. (½ gr.)	30 mg.
Glutamic Acid	50 mg.
Thiamine HCL	10 mg.

Dose: 1 tablet 3 times daily.
Available:
Bottles of 100, 500, 1000.

Android-X
EXTRA HIGH POTENCY

Each orange tablet contains:

Methyl Testosterone	12.5 mg.
Thyroid Ext. (1 gr.)	64 mg.
Glutamic Acid	50 mg.
Thiamine HCL	10 mg.

Dose: 1 or 2 tablets daily.
Available:
Bottles of 60, 500.

Android-Plus
WITH HIGH POTENCY
B-COMPLEX AND VITAMIN C

Each white tablet contains:

Methyl Testosterone	2.5 mg.
Thyroid Ext. (¼ gr.)	15 mg.
Ascorbic Acid (Vit. C)	250 mg.
Thiamine HCL	25 mg.
Glutamic Acid	100 mg.
Pyridoxine HCL	5 mg.
Niacinamide	75 mg.
Calcium Pantothenate	10 mg.
Vitamin B-12	2.5 mcg.
Riboflavin	5 mg.

Dose: 2 tablets daily.
Available: Bottles of 60, 500.

Contraindications — Methyltestosterone is not to be used in malignancy of reproductive organs in male, coronary heart disease. Thyroid is not to be used in heart disease, hypertension unless the metabolic rate is low.

References: 1. **Montesano, P., and Evangelista, I.** Methyltestosterone-thyroid treatment of sexual impotence. Clin Med 12:69, 1966. 2. **Dublin, M. F.** Treatment of impotence with methyltestosterone-thyroid compound. West Med 5:67, 1964. 3. **Titeff, A. S.** Methyltestosterone-thyroid in treating impotence. Gen Prac 25:6, 1962. 4. **Hellman, L., Bradlow, H. L., Zumoff, B., Fukushima, D. K., and Gallagher, T. F.** Thyroid-androgen interrelations and the hypocholesteremic effect of androsterone. J Clin Endocr 19:936, 1959. 5. **Farris, E. J., and Colton, S. W.** Effects of L-thyroxine and liothyronine on spermatogenesis J Urol 79:863, 1958. 6. **Osol, A., and Farrar, G. E.** United States Dispensatory (ed. 25). Lippincott, Philadelphia, 1955, p. 1432. 7. **Wershub, L. P.** Sexual Impotence in the Male. Thomas, Springfield, Ill., 1959, pp. 79-99.

REFER TO PDR

ite for literature and samples: BROWN THE BROWN PHARMACEUTICAL CO., INC. 2500 West 6th Street, Los Angeles, California 90057
A SUBSIDIARY OF ASSOCIATED CARE ENTERPRISES, INC

Classified Advertising

$5.00 per insertion of 50 words or less, with an additional 10 cents per word in excess of 50.

FAMILY PRACTICE PHYSICIANS — Board of Trustees of St. Mary's Hospital in Marquette invites family practice physicians to practice in Michigan's upper peninsula. This community has two hospitals, excellent schools, churches and year-round sports activities. This hospital is a 126 bed modern, well equipped, JCAH accredited general hospital including psychiatric and rehabilitation units in which to practice professional skills. Interested physicians may contact: Archie S. Narotzky, M.D., Chief of Staff, St. Mary's Hospital, Marquette, Michigan 49855.

ANN ARBOR—YPSILANTI AREA. 3 yr. AMA approved, university affiliated psych. residency at mental health center offering comprehensive services to SE Mich. Teaching faculty & supervisors include U. of M. faculty, private psychiatrists & analysts, as well as hospital staff. Resident's time divided approx. equally between didactic seminars (including supervision) & clinical experience. First year ADM & Intensive Treatment Units; second & third year assigned Community Psych. and/or OPC and/or Children's unit. Additional experience in psychosomatic medicine, Univ. Mental Hygiene Clinic, and neurology. 3-year: $11,358 to $12,924. 5-yr: $12,945 to $23,197. $15,000 NIMH grants & dependency allowance ($500 per) available to eligible physicians in practice 4+ years. Contact: J. Tiziani, M.D., Ypsilanti State Hospital, Ypsilanti, Michigan 48197.

General Surgeon wishes to locate in State of Michigan. Would consider any area except city of Detroit. Would consider Association or group practice in General and Industrial Surgery. Reply Box 19, 120 W. Saginaw Street, East Lansing, Michigan 48823.

Semi-retire in Florida!! Clean air, fishing and beaches. Emergency room physicians needed full time for expanding Florida Hospital. Must have Florida License and qualify for Active Staff privileges. Fee for service with Guarantee of $300 per 24 hour day. No overhead. Hospital does billing of fees at no expense to you. Write E. Gilbert Slatton, Administrator, Wuesthoff Memorial Hospital, Rockledge, Florida 32955.

PSYCHIATRIC RESIDENCIES: We offer excellent approved, psychiatric training which is both demanding and well-organized in a clinically rich, stimulating program. The setting is in a culturally satisfying community; the serene, scenic Grand Traverse Bay area with year-round cultural and recreational activities. Salary: 3 year programs $11,359, $11,922, $12,925. Five year program: $12,945, $14,950, $17,393, $23,198, $24,409. Contact Dr. Paul E. Kauffman, Director of Training Department (MI), Traverse City State Hospital, Traverse City, Michigan 49684. An equal opportunity employer.

WANTED: Internist to join two man partnership in Michigan's upper thumb area. Excellent recreation and educational facilities are available. Write to: K. B. Herrington, M.D. or Kenneth S. Kube, M.D., 669 South Van Dyke, Bad Axe, Michigan. May call collect: (517) 269-6453.

Chief of Medical Staff — Regular hours, $30,589 annually, excellent fringe benefits. Smog free, peaceful, cultural, vacationland community. Sound Great? It's all yours if you are a boarded internist or generalist. Apply to M. Duane Sommerness, M.D., Box C, Room 246, Traverse City State Hospital, Traverse City, Michigan 49684. An equal opportunity employer.

ANESTHESIOLOGIST: Age 42, married, University trained (Canada). Experienced in all types of anesthetics including pediatrics. Would like to relocate in Wayne, Genesee, Oakland, Washtenaw or Ingham counties. Will consider other replies. Reply Box 17, 120 W. Saginaw Street, East Lansing, Mi 48823.

Internist, OB-GYN, Radiologist, and Urologist needed for additional staff to established 15 man medical group in Detroit. Excellent financial opportunities and fringe benefits. Box 20, 120 West Saginaw Street, East Lansing, Michigan 48823.

NEW EXPANDING OPPORTUNITIES for family physicians and physicians specializing in pediatrics, internal medicine, urology, anesthesiology; in medically-awakening community. Contemporary, automated, 105-bed, new hospital to be completed in the fall of 1970. Present hospital to be converted into long-term unit. Patient service area 50,000 people. Medical staff leading and supporting recruitment efforts. Excellent community location, forty miles equidistant to Milwaukee or Madison. Complete educational, cultural and recreational facilities. A new medical — dental building and a 130-bed skilled care nursing home being constructed adjacent to the new hospital ready for occupancy January 1971. Immediate satisfaction in practice, income and family living. Special assistance if needed. Write or call Paul R. Glunz, M.D., Watertown Memorial Hospital, 1301 E. Main Street, Watertown, Wisconsin 53094; Telephone (414) 261-4210 for more information.

VACATION ON FLORIDA'S GOLD COAST: 2 bedroom T-bird villa in Coral Springs. Quiet and private. 18 hole golf course, tennis, swimming pool on premises. Available year-round on monthly or weekly rental basis. Rest and recuperate that weary mind and body. Contact Dr. J. Heidenreich, Marshall, Michigan (616) 781-7997.

DRUG ABUSE PROJECT DIRECTOR — $1,000,000 program. Excellent liaison with local universities. Unusual opportunity for development of innovative techniques. Salary $29,484 per year. Drug abuse experience desirable. Must be able to obtain California license. Requires M.D., masters degree in public health, plus one year related experince. One additional year's experience may be substituted for masters degree. Appointment at lower salary level and future promotion possible for applicant lacking any experience or lacking masters degree. Excellent fringe benefits. Direct resumes to Doctor B. A. Kogan, Director of Medical Services Bureau, Los Angeles County Health Department, 220 N. Broadway, Los Angeles, California 90012. Telephone (213) 625-3212, Extension 225.

Allergist or internist interested in allergy desired as associate in the Rochester, Michigan area. Favorable terms. Reply: Box 21, 120 West Saginaw Street, East Lansing, Michigan 48823.

RADIOLOGIST, full-time, for accredited hospital in Detroit. Excellent remuneration. Reply to Box 16, 120 West Saginaw Street, East Lansing, Michigan 48823.

A GENERALIST OR INTERNIST for admitting Outpatient Clinic. 40 hour week. 30 day leave. With excellent fringe benefits in beautiful University City with many cultural advantages. Salary range $22,000 to $29,000, depending upon experience and training. Write or call Chief of Staff, VA Hospital, Ann Arbor, Michigan. Telephone (313) 769-7100, Ext. 331.

WANTED: General practitioner to join active group in large non-OB, non-pediatric practice with large industrial component. Well established. New building. X-Ray—Laboratory facilities—Cincinnati area. Future bonanza for right person willing to work. Reply Box 18, 120 West Saginaw Street, East Lansing, Michigan 48823.

WANTED: Partner-Associate for busy family practice in N.W. Detroit suburb. No OB. Rapidly expanding area with nearby hospital expansion underway. Terms open. Reply: Box 22, 120 W. Saginaw St., East Lansing, Michigan 48823.

Index to Advertisers

Arch Laboratories	957
Breon Laboratories	867
Brown Pharmaceuticals	955
Burroughs-Wellcome	894
Campbell Soup Co.	893
Carlton Corp., The	933
Classified Advertising	956, 957
Dow Chemical Co.	925, 926, 927, 928
Hynson, Westcott and Dunning, Inc.	863
Ingram, G.A. and Co.	933
Lederle Laboratories	864, 931, 942, 943
Lilly, Eli and Co.	872
Mallard, Inc.	909, 910
Mead-Johnson and Co.	922, 923
Medical Protective Co.	917
Mercywood Hospital	953
Merck, Sharp and Dohme	898, 899, 900
Michigan State Medical Society	865
Multivest Real Estate Fund	957
National Drug Co.	895, 896, 935, 936
Plainwell Sanitarium	947
Poythress, Wm. P.	905
Professional Service Corp.	945
Robins, A.H.	918, 919, 920
Roche Laboratories	906, 907, 908, 948, 949, Cover IV
Sandoz Pharmaceuticals	937, 938, 939, 940
Searle, G.D. and Co.	902, 903
Smith, Kline and French Laboratories	Cover II
Stratton, Ben P., Insurance	Cover III
University of Michigan	866
Walker Corp. and Co.	912, 913

Taste!

Dicarbosil®
ANTACID

Your ulcer patients and others will love it. Specify DICARBOSIL 144's—144 tablets in 12 rolls.

ARCH LABORATORIES
319 South Fourth Street, St. Louis, Missouri 63102

2,000 LIMITED PARTNERSHIP UNITS
IN MULTIVEST
REAL ESTATE FUND, LTD.
$2,500 Per Unit

The Partnership intends to invest its funds in real properties which the General Partner considers will offer a potential for profit either through the production of income or through gain on resale. Secondarily, when feasible within these objectives, the Partnership will also attempt to provide tax shelter for participants. At least 90% of investments will be in existing income producing real estate.

This announcement is neither an offer to sell nor a solicitation of an offer to buy these securities. This offer is made only by the prospectus in states where authorized, in compliance with state requirements. The Prospectus may be obtained from Multi-Vest Real Estate, Inc., or an authorized security dealer in any state where such offer may lawfully be made.

MultiVest Real Estate, Inc.

Mail Coupon Today or Call (313)352-3100
P.O. Box 550, Southfield, Michigan 48075
Gentlemen:
Please send me the free prospectus concerning MultiVest Real Estate Fund, Ltd.
NAME ____________________
ADDRESS ____________________
CITY ________ STATE ________ ZIP ______
PHONE NO: ____________________ MedA

noted and quoted

BY HERB AUER, EXECUTIVE EDITOR

The proportion of employed women has risen most sharply for women over 35, according to a survey by Young & Rubicam. The study found that the median age of working women is now 40. "Forty-nine percent of all women between the ages of 33 and 44 are employed, and by next year, more than one-half of this group will be working outside of the home," the report says. "The women in their mid-thirties who return to the labor force generally have been out for 8 to 10 years. If they re-enter when they are 35 years of age and have no children, they can expect to average 24 years of work."

A related study by *Time* magazine found that all women—but especially working women—are tending to fewer children in the USA.

* * *

An address by W. Marcellus Leonard, of St. Francis College, Loretto, Pa., to young people has been quoted many, many times. In part, he says: "I offer no apologies for my generation. I am proud of it, and what we have built on the foundation left us. I hope that you will do as well. You will if you will leaven your zeal with a little humor, your egotism with a little history, and ask why your insistence on universal love seems so often to express itself in hate for those who differ from you."

* * *

The magnitude of the problem of medical devices is described in a recent issue of the *Bulletin of the American College of Surgeons.* The journal reports that, "physicians are confronted with an estimated 5,000 types of devices, produced by over 1,300 manufacturers, and rapture has given way to a more realistic appraisal of the difficulties associated with the use of such devices in humans."

The article also points out that "physicians are not trained in electronics, metallurgy, or polymer chemistry, which would enable them to judge the safety and effectiveness of many devices they encounter and use in their practice."

* * *

Alfred S. Julien, of New York City, past president of the American Trial Lawyers Association, spoke recently to the Ingham County Medical Society and told them there hasn't been any proliferation in malpractice suits, notwithstanding articles in medical journals.

There are more patients, patients have longer hospital stays, and there is so much more in treatments, the attorney said. The statistics are meaningless and indicative of the pace of the times, he added.

* * *

In his new book, *Medicare,* Robert J. Myers presents a comparison of annual increases in physicians' fees and in general wages. His comparison reveals that from 1956 through 1968, the average annual increase in physicians' fees was .5 *below* the average annual increase in general wages. During the 12-year period, wages rose an average of 4.2% each year. Physicians' fees went up 3.7%.

The comparison doesn't tell the whole story. It should be noted that a physician's fee must include 35 to 40% for overhead and that the physician must provide his own fringe benefits from the fee. Most wage earners have no overhead and their fringe benefits — 15 to 20% of their annual salaries — are provided in addition to their wages. If these two factors were deducted from physicians' fees, we find that the increase in physicians' "wages" has lagged far behind the annual increase in the wages of others — even during the unusual economic period following enactment of Medicare.

* * *

The Pharmaceutical Manufacturers Association continues to run effective ads in many national magazines.

A recent one declared: "Out of every thousand chemicals tested in animals, we find eight worth testing in humans. From blackboard to pharmacy shelf, the research, development, and other sophisticated procedures cost, on the average, $7,000,000 per major marketed product. It's a long, tedious, and expensive process. But it has one big advantage: it protects the public."

* * *

Did you know . . . that many, many more boats go *over* the Mackinac Bridge than go *under* it!

The Michigan Press Association reports that a recent 48-hour survey found that 1,205 of the 16,605 northbound vehicles were either pulling or carrying boats. The same ratio existed for southbound traffic—meaning more than 2,400 boats went over the Mackinac Bridge.

During the same period only 240 boats actually went under the bridge on water.

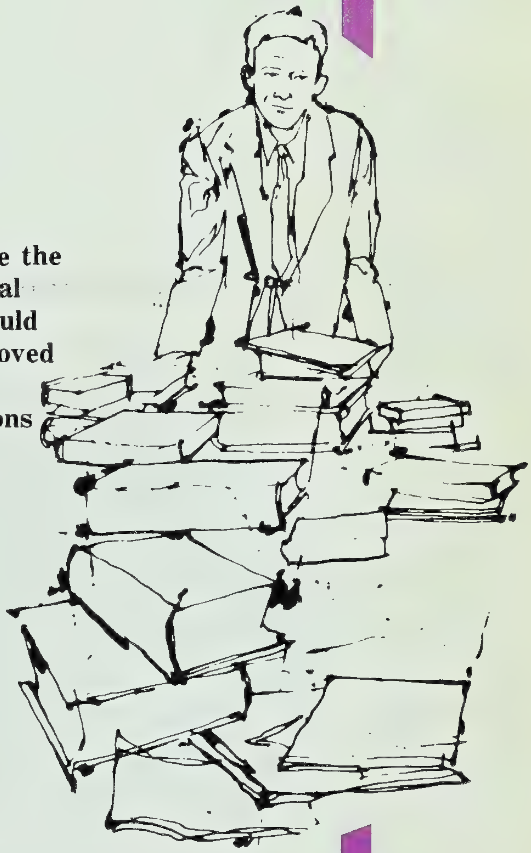
michigan medicine

FEATURES IN THIS ISSUE

- Non-Invasive Approaches to Cardiac, Vascular and Pulmonary Dynamics
- Can a Quasi-Public Corporation Control Michigan Health Care Programs?
- How to Make County Medical Societies More Relevant to Members

U. C. SAN FRANCISCO
MEDICAL CENTER LIBRARY
NOV 20 1970

How does the Michigan physician rate the current offerings in postgraduate medical education in the state? In what ways could postgraduate medical education be improved in Michigan? The first installment in a series of articles answering such questions begins in this issue, on page 981. Be sure to read it.



**Michigan State Medical Society
November 1970, Volume 69, Number 21**

Medical technology is demanding enough--

Here's how to relieve the demands of business:

— and enjoy personal satisfaction, peace of mind and freedom of time greater than you may have imagined possible.

Just a few years ago, a group of doctors in Kentucky resolved to make their practices simpler and more profitable. They formed a non-profit corporation, the Professional Service Corporation Association. The doctors talked with many professional consultants. Together they explored every aspect of practice — office procedure, billing, accounting, salaries, fringe benefits, insurance, retirement, equipment — even auto leasing — literally every business demand. Time and energy were lavished on every detail. Each was honed, polished and perfected. Now, benefits in each of these areas are available to PSCA members.

Specific business guidelines are the key

You may unknowingly be using business techniques discarded years ago by professional businessmen. You may be needlessly hampered by restrictions — penalized by advice from persons not knowledgable in medicine. Today, PSCA guidelines for systematic and simplified business procedures can be applied to incorporated practices. Remarkable benefits are immediately available.

Get every benefit you're entitled to

Professional Service Corporation Association (PSCA) offers members complete guidance to qualify for every benefit legitimately available. You'll find this list surprisingly long. Exceptional financial rewards are possible. Details of planned incentives and benefits for employees are covered. Carefully qualified and professional services are made available exclusively to PSCA members.

Direct and immediate cash savings — three and four times your membership fee — may be realized in a single business transaction.

Here's how you can get these remarkable benefits

Regular PSCA membership is open to incorporated professionals exclusively. Junior membership to qualified senior students, interns, residents and fellows. Dues for Regular membership are $25 for each stockholder-employee per year. $10 for Junior members. Complete the coupon below and send it with your check today. You'll be provisionally enrolled until qualification is approved. Benefits of membership come just as easily as this means of joining. Full information covering all details will start you enjoying your chosen profession as never before.

Professional Service Corporation Association, Inc.
A non-profit organization formed and controlled by doctors
1622 Commonwealth Building, Louisville, Ky. 40202
Phone: 502/583-8164

To PSCA: Enroll me as a ☐ Regular ☐ Junior member for one year. My practice specialty is________________.
Send full information and details to:

NAME______________________________

TITLE______________________________

CORPORATE NAME________________________

ADDRESS____________________________

CITY______________STATE________ZIP______

(Your fee is refundable if you do not qualify.)

Breaking News: Deadline Oct. 9
October 1970, Volume 69, Number 20
Michigan State Medical Society

michigan medicine

U. C. SAN FRANCISCO
MEDICAL CENTER LIBRARY

NOV 6 1970

Doctor Hiscock Installed; Doctor Adler New President-Elect; Doctor Taylor Re-elected

The leaders of the Michigan State Medical Society for 1970-71 are:

President: Harold H. Hiscock, M.D., Flint
President-elect: Sidney Adler, M.D., Detroit
Speaker: Vernon V. Bass, M.D., Saginaw
Vice-speaker: James D. Fryfogle, M.D., Detroit
Council Chairman: Ross V. Taylor, M.D., Jackson
Council Vice-chairman: Brooker L. Masters, M.D., Fremont

The new slate of officers assumed duties at the 1970 Annual Session, along with others who were selected to serve on The MSMS Council or in the MSMS delegation to the AMA House of Delegates.

Doctor Adler was chosen president-elect in the final session Sept. 22 of the House. An internist, he is a past president of the Michigan Medical Service (Blue Shield) and has served as a member of The MSMS Council for several years. Doctor Adler is a graduate of the Johns Hopkins Medical School and has practiced in Detroit since 1935.

Also at that final 1970 session, the MSMS delegates elected former Vice-speaker Vernon V. Bass, M.D., to serve as speaker, and chose James D. Fryfogle, M.D., as new vice-speaker. The House expressed its warm appreciation to outgoing speaker James B. Blodgett, M.D., Detroit, for his years of expert leadership.

Doctor Hiscock was installed as the new president at a special dinner Sept. 22. He succeeds Robert J. Mason, M.D., of Birmingham.

When The Council re-organized on Sept. 23, the councilors re-elected Chairman Ross V. Taylor, M.D., and chose Brooker L. Masters, M.D., former Publication Committee chairman, as new vice-chairman. Ralph R. Cooper, M.D., Detroit, was elected County Societies Committee chairman, and Robert M. Leitch, M.D., Union City, Publication Committee chairman, and Ernest P. Griffin, Jr., M.D., Flint, Finance Committee chairman.

Four delegates and four alternate delegates were chosen for two-year terms in the AMA House of Delegates. Returned as delegates were Donald N. Sweeny, Jr., M.D., Detroit; George W. Slagle, M.D., Battle Creek, and Joseph A. Witter, M.D., Rochester, while John J. Coury, M.D., Port Huron, was newly-elected as a delegate. Re-elected alternate delegates were James C. Dansforth, Jr., M.D., Detroit; Marjorie Peebles-Meyers, M.D., Detroit and Vernon V. Bass, M.D., Saginaw, while

THREE CONSECUTIVE LEADERS of MSMS Affairs are, from left, Robert J. Mason, M.D., Birmingham, immediate past president; Harold H. Hiscock, M.D., Flint, 1970-71 president, and James J. Lightbody, M.D., Detroit, 1968-69 president.

Blue Shield Corporate Body to Reorganize; 15 New Board Members Selected

The Blue Shield corporate body voted 113-75 in a secret ballot Sept. 22 to restructure the organization along lines proposed by the Blue Shield Board of Directors.

In addition, 15 members were elected to the board of directors at the Sept. 22 meeting in Detroit held during the 105th annual meeting of MSMS.

Approval of the structural changes must come from Russell E. Van Hooser, state insurance commissioner. He already has indicated tentative approval of the suggested changes.

Under the new plan, doctors, pharmacists and hospital representatives would have 47.2 percent of the representation on both the corporate body and the board of governors. Another 41.7 percent of the representation on the corporate body and the board of directors would go to members of labor, industry and subscriber groups, and the remaining 11.1 percent would be selected from the public at large.

Thus, physicians, who have controlled Michigan Blue Shield since it was formed in 1939, have voted to give laymen a majority voice on both the Blue Shield corporate body and its board of directors.

Elected to serve as members of the Board were Kenneth J. Boekeloo, vice president of finance and comptroller, Michigan Bell Telephone Co.; Earl E. Conklin, senior executive vice president, Ex-Cell-O Corp.; John R. Cooke, vice president of industrial relations, Bendix Corp.; Roy J. Gerard, M.D., Saginaw general practitioner; William R. Gladstone, Jr., M.D., Norway general practitioner; Stuart M. Gould, Jr., M.D., Ann Arbor psychiatrist; Robert H. Hamburg, M.D., Detroit internist; Benjamin Jeffries, M.D., Harper Woods psychiatrist; Howard N. Maynard, president, Snyder Corp.; Richard J. McMurray, M.D., Flint obstetrician-gynecologist; Ernest J. Moran, assistant to the president, UAW; Carl H. Morgenstern, chairman of the board, Old Kent Bank and Trust Co.; Elmore E. Pollock, consultant, the Wyatt Co.; Thomas Turner, president, Metropolitan Detroit AFL-CIO, and Walter J. Zimmerman, M.D., Royal Oak internist.

Continued: New MSMS Officers

Robert C. Prophater, M.D., Bay City, was newly-elected.

Continuing to serve another year as delegates are Otto K. Engelke, M.D., Ann Arbor; John R. Heidenreich, M.D., Daggett; Luther R. Leader, M.D., Royal Oak, and Robert E. Rice, M.D., Greenville.

The MSMS House elected seven new members of The Council, in addition to Doctor Fryfogle. New representatives of the first district are Edward J. Tallant, M.D., Frank B. Bicknell, M.D., and Brock E. Brush, M.D., all of Detroit. Doctor Brush was chosen to complete the unexpired term of Doctor Adler. Other new councilors are W. Kaye Locklin, M.D., Kalamazoo, fourth district; Noyes L. Avery, Jr., M.D., Grand Rapids, fifth district; Donald T. Anderson, M.D., Kingsford, 13th district, completing the unexpired term of John R. Franck, Jr., M.D., Wakefield, who resigned his post, and Donato F. Saparo, M.D., Adrian, 14th district.

Returned to The Council were Ralph R. Cooper, M.D., Detroit, first district, and Ernest P. Griffin, Jr., M.D., Flint, sixth district.

AMA Clinical Convention Nov. 29-Dec. 2 in Boston

Approximately 7,500 physicians, guests, medical students, residents, nurses, allied health professionals and industrial and scientific exhibitors are expected at the 24th Clinical Convention of the AMA Nov. 29-Dec. 2 in Boston. The program for the convention will be published in the Oct. 19 issue of the *Journal of the American Medical Association.*

Dr. Levitt Takes California Post

Morton Levitt, Ph.D., dean of the Wayne State University School of Medicine from 1957 until his resignation last spring, began duties Sept. 1 as associate dean for academic affairs at the University of California School of Medicine at Davis. He was also appointed professor of psychiatry at the medical school, California's newest.

Doctor Levitt was assistant dean for admissions and student affairs at WSU's School of Medicine from 1947 to 1963. He joined the medical faculty in 1951 as instructor in psychiatry and was appointed full professor in 1961.

National Cancer Society Awards $50,000 to U-M

The American Cancer Society has awarded $50,000 to the University of Michigan in an institutional research grant. It is the 18th consecutive annual grant to the university's Cancer Research Institute by the society.

The proceedings will be printed in December as part of **Michigan Medicine.**

A HEARTY HANDSHAKE signals the transfer of leadership from immediate past speaker of the MSMS House of Delegates James B. Blodgett, M.D., center, to Vernon V. Bass, M.D., former vice speaker and new speaker, left. James D. Fryfogle, M.D., right, is new vice speaker of the House.

Unofficial Summary Of House Action

By Vernon V. Bass, MD
Speaker
MSMS House of Delegates

The following summary report of the proceedings of the 105th (1970) House of Delegates of the Michigan State Medical Society is *UNOFFICIAL.*

It is designed to assist delegates in reporting to their medical societies prior to the publication of the official stenotyped record which is printed in *Michigan Medicine,* the Society's monthly journal.

The number of the resolution and the reference committee that considered it are indicated after each House action. Actions involving more than one subject are repeated under each applicable subject heading.

Matters of General State Society Business

The House amended the Constitution and Bylaws by:

A. Redefining the purpose of MSMS. (Ref. Rept. Const. & Bylaws)

B. Granting the Secretary and Treasurer the right to vote on The Council. (Ref. Rept. Const. & Bylaws)

C. Granting the Secretary and Treasurer the right to vote on the Executive Committee of The Council. (Ref. Rept. Const. & Bylaws)

D. Granting Specialty Section Delegates the right to vote. (Ref. Rept. Const. & Bylaws)

E. Adding to the composition of the House of Delegates a delegate from each Student American Medical Association chapter of each established medical school in the State of Michigan. (Res. 109, Ref. Rept. Const. & Bylaws)

The House requested the Judicial Commission to consider the ethical aspects of payment of physician charges by credit cards. (Res. 82 as amended, Ref. Rept. Public & Pro. Rel.)

The House reaffirmed the MSMS policy on abortions as adopted by the 1968 House of Delegates. (Res. 31, Ref. Rept. Resolutions)

The House referred Resolution 33 to the Michigan Delegates to the AMA that the AMA direct component state and county medical societies, in cooperation with local hospital associations or groups, to institute Boards of Arbitration to mediate hospital-physician disputes. (Res. 33 as amended, Ref. Rept. Pub. & Pro. Rel.)

The House authorized the continuation and completion of the Professional Management Study for the re-evaluation and reorganization of the Society. (Ref. Rept. Ways and Means)

Matters Pertaining to Blue Shield

The House disapproved all resolutions calling for disassociation as a group from Blue Shield. (Res. 4, 5, 55, 72, 77, 78 and 79, Ref. Rept. Health Ins. & Med. Serv.)

The House disapproved a resolution to recall and remove from office the entire Blue Shield Board of Directors. (Res. 88, Ref. Rept. Health Ins. & Med. Serv.)

The House disapproved the plan for restructuring the Michigan Medical Service as submitted by its Board of Directors. (Res. 99, Ref. Rept. Health Ins. & Med. Serv.)

The House adopted the AMA Current Procedural Terminology (C.P.T.) and retired the Michigan Relative Value Study (MRVS). Urged Michigan Medical Service to use the C.P.T. for reporting of services in determination of payments. Implementation to be accomplished when financially feasible

Sidney Adler, M.D., Detroit, new president-elect of the Michigan State Medical Society, addresses the full body of the House following his election Tuesday night, Sept. 22, by the MSMS House of Delegates.

Continued: Unofficial Summary of House Action

and in concert with the National Association of Blue Shield Plans. (Res. 3 as amended, Ref. Rept. Health Ins. & Med. Serv.)

The House reaffirmed its support of individual case participation. (Res. 18, Ref. Rept. Health Ins. & Med. Serv.)

The House upheld the policy of nondiscrimination in payment to subscriber for services rendered by non-participating physicians. (Res. 19 as amended, Ref. Rept. Health Ins. & Med. Serv.)

The House requested a change in Blue Shield policy that would accept billings for professional services provided by professional corporations upon submission of a report approved by the authorized representative of that professional corporation. (Res. 76, Ref. Rept. Health Ins. & Med. Serv.)

The House concurred with The Council recommendation that MSMS not reimburse physician members of the Blue Shield Board. (Res. 37, Ref. Rept. Pub. & Pro. Rel.)

The House requested Blue Shield, Medicaid and all other insurance and government medical plans to remove restriction on payment for surgical sterilization. (Res. 95 as amended, Ref. Rept. State & Fed. Leg.)

Matters Pertaining to Education

The House urged the Regents of our medical schools to accept as full time students in medicine those with a minimum of two years of pre-medical education with a major emphasis on the Humanities and Social Sciences. (Sub. Res. for 7, 13, 29, 50, 85, and 96, Ref. Rept. Pub. & Pro. Rel.)

The House endorsed the principle of voluntary life-long postgraduate study for all physicians. (Res. 34, Ref. Rept. Res.)

The House endorsed the pilot program of physician-assistants of Western Michigan University. (Res. 84 as amended, Ref. Rept. Pub. & Pro. Rel.)

The House urged physicians to take leadership in providing training for persons concerned with the immediate care of the acutely ill or injured on a continuing basis. (Res. 21 as amended, Ref. Rept. Pub. & Pro. Rel.)

The House reaffirmed the endorsement of the need for an educational program to help combat crime and drug abuse as contributing to over all morbidity. (Res. 105 as amended, Ref. Rept. Res.)

The House urged the Michigan Health Council and others to expand educational programs on drugs. Urged medical schools, hospitals and medical societies to establish educational programs on drug dependence. (Sub. Res. for 26 & 27, Ref. Rept. Pub. & Pro. Rel.)

The House expressed appreciation to the Michigan State Legislature for passage of S.B. 1179 providing $195,000 additional allowance for medical schools. (Res. 91, Ref. Rept. State & Fed. Leg.)

The House directed The Council to investigate various incentives which could be used to encourage physicians to practice in areas where there is an acute shortage of physicians. Directed The Council and Delegates to the AMA to urge medical schools to increase the use of their staffs and facilities. (Sub. Res. for 13, 29 & 58, Ref. Rept. Misc. Bus.)

Matters Pertaining To Legislation and Government

The House determined that a comparable number of providers, preferably practicing physicians should be added to the State Advisory Council on Comprehensive Health Planning for each additional consumer representative. (Res. 63, Ref. Rept. Misc. Bus.)

The House commended the State Comprehensive Health Planning Advisory Council for opposing S.B. 1756 which would cover chiropractic services under Blue Shield. (Res. 64, Ref. Rept. Misc. Bus.)

The House decided to resist all attempts to repeal anti-substitution legislation. (Res. 93 as amended, Ref. Rept. Misc. Bus.)

The House opposed the Bennett Amendment 851 to Social Security Amendments, HR 17550. (Res. 107, Ref. Rept. State & Fed. Leg.)

The House supported all sound efforts to prevent further pollution of the Great Lakes; endorsed in principle plans for reclamation and restoration of polluted waters and urged enforcement of laws relating to pollution control. (Res. 20 as amended, Ref. Rept. Pub. & Pro. Rel.)

The House requested the Commissioner of Health to rescind/or modify the present regulation to conform with the recommendation of the American Red Cross that a physician need not be actually present at blood donor clinics. (Res. 80, Ref. Rept. Res.)

The House expressed appreciation to the Michigan State Legislature for passage of S.B. 1179 providing $195,000 additional allowance for medical schools. (Res. 91, Ref. Rept. State & Fed. Leg.)

The House recommended amending the Medical Licensure Act to allow physicians with proper credentials to be given a temporary license. (Res. 9, Ref. Rept. State & Fed. Leg.)

The House encouraged all component medical societies to establish periodic liaison with area legislators. (Res. 12, Ref. Rept. State & Fed. Leg.)

The House supported necessary legislation to implement the goals outlined by the Governor in his special message on drug abuse. (Sub-Res. for 25, 43 & 75, Ref. Rept. State & Fed. Leg.)

The House resolved that MSMS should seek expansion of the Medicaid program to include reimbursement to physicians for immunization procedures. (Res. 28, Ref. Rept. State & Fed. Leg.)

The House decided to continue the MD Volunteer Lobbying Program. (Res. 38, Ref. Rept. State & Fed. Leg.)

The House objected to reimbursement of chiropractors in federally-funded health programs. (Res. 39, Ref. Rept. State & Fed. Leg.)

The House resolved to repeal the Basic Science Act in its entirety. (Res. 83, Ref. Rept. State & Fed. Leg.)

The House urged the expansion of home health services under Medicare and Medicaid. (Res. 101, Ref. Rept. State & Fed. Leg.)

The House resolved that MSMS propose legislation that would require insurance companies doing business in Michigan to provide coverage for all licensed physicians. (Res. 106 as amended, Ref. Rept. State & Fed. Leg.)

The House requested Blue Shield, Medicaid and all other insurance and government medical plans to remove restrictions on payment for surgical sterilization. (Res. 95 as amended, Ref. Rept. State & Fed. Leg.)

The House directed The Council to develop a fee schedule satisfactory to the medical profession for all professional contractual relationships with governmental agencies wherever or whenever this is necessary. (Res. 81 as amended, Ref. Rept. Pub. & Pro. Rel.)

The House agreed with the recommendation of The Council that a legal suit on the freezing of Medicare fees is not feasible. (Ref. Rept. Council & Officers)

The House resolved that MSMS take action through its Legal Affairs Committee to declare that drug intoxication and addiction constitute a disease and should be a Medicaid benefit. (Res. 48 as amended, Ref. Rept. State & Fed. Leg.)

The House resolved that MSMS through its Legal Affairs Committee request the Legislature to approve more adequate amounts of money for approved alcohol programs. (Res. 65 as amended, Ref. Rept. State & Fed. Leg.)

The House directed The Council to seek suitable legislation that would allow minors (ages 16 to 21) to give their own consent for examination (including pelvic). (Sub. Res. for 74 & 94, Ref. Rept. State & Fed. Leg.)

The House directed The Council to seek legislation that would make it an offense to allow and/or condone the use of narcotics and dangerous drugs within a residence. (Res. 73 as amended, Ref. Rept. State & Fed. Leg.)

Matters Pertaining To The Council and Committees

The House directed The Council to investigate various incentives which could be used to encourage physicians to practice in areas where there is an acute shortage of physicians. Directed The Council and Delegates to the AMA to urge medical schools to increase the use of their staffs and facilities. (Sub. Res. for 13, 29 & 58, Ref. Rept. Misc. Bus.)

The House amended the recommendation of The Council to direct that an annual membership directory be published with listing by component societies with a city-county cross indexing. (Res. 40 as amended, Ref. Rept. Misc. Bus.)

The House directed The Council to investigate the desirability of forming a medical foundation

More articles and photos of 1970 Annual Session will appear in November issue of MICHIGAN MEDICINE.

Continued: Unofficial Summary of House Action

in Michigan and if found desirable, take the necessary steps for forming such a foundation. (Res. 100 as amended, Ref. Rept. Misc. Bus.)

The House directed The Council to study available health insurance plans for members and their employees as offered by some "Blue" plans (e.g., Kansas City) and other commercial carriers. (Res. 6 as amended, Ref. Rept. Pub. & Pro. Rel.)

The House directed The Council to develop a fee schedule satisfactory to the medical profession for all professional contractual relationships with governmental agencies wherever or whenever this is necessary. (Res. 81 as amended, Ref. Rept. Pub. & Pro. Rel.)

The House directed The Council to exert greater efforts in joint development in planning with Michigan Hospital Association. (Res. 103, Ref. Rept. Pub. & Pro. Rel.)

The House approved the continuation of the annual Councilor conferences as recommended by The Council. (Ref. Rept. Council & Officers)

The House agreed with the recommendation of The Council that a legal suit on the freezing of Medicare fees is not feasible. (Ref. Rept. Council & Officers)

The House directed The Council to study the feasibility of forming an Advisory Committee of Consumers. (Ref. Rept. Council & Officers)

The House directed The Council to study the feasibility of supporting a "Youth Week in Health" program. (Ref. Rept. Council & Officers)

The House urged that the Relative Value Study Committee update the RVS including the AMA, C.P.T. coding. (Ref. Rept. Council & Officers)

The House recommended that The Council compile figures regarding the overhead cost of medical practice. (Ref. Rept. Council & Officers)

The House directed The Council to utilize the Socio-Economic and Hospital Relations Committees to aid the Rehabilitation Committee in forming guidelines for rehabilitative care in acute hospitals or extended care facilities. (Sub. Res. for 45 & 67, Ref. Rept. Res.)

The House referred recommendations for elimination of the legal profession's contingency fee system to The Council for more study. (Res. 44 and 92, Ref. Rept. State & Fed. Leg.)

The House directed The Council to seek suitable legislation that would allow minors (ages 16 to 21) to give their own consent for examination (including pelvic). (Sub. Res. for 74 & 94, Ref. Rept. State & Fed. Leg.)

The House directed The Council to seek legislation that would make it an offense to allow and/or condone the use of narcotics and dangerous drugs within a residence. (Res. 73 as amended, Ref. Rept. State & Fed. Leg.)

The House instructed The Council to set up a Bureau of Economic Information and increased dues $10.00 per annum per dues-paying member for the purpose of initiating and implementing the Bureau. (Sub. Res. for 10, 46, 47, 70 & 90, Ref. Rept. Ways & Means)

The House authorized the continuation and completion of the Professional Management Study for the re-evaluation and reorganization of the Society. (Ref. Rept. Ways & Means)

The House approved the development of dues related member benefit programs and directed The Council to develop and propose to the 1971 House, a Member Assistance Fund for needy physicians. (Ref. Rept. Ways & Means)

The House referred Resolution 51 "Formation of Michigan State Hospital Staff Association" to the Hospital Relations Committee of The Council for investigation and report to the 1971 House of Delegates. (Res. 51, Ref. Rept. Res.)

The House referred Resolution 56 as amended "Disposal of Disposables" to the Public Health Committee for consideration and implementation. (Res. 56, Ref. Rept. Res.)

The House referred the problem of multiplicity of hospital inspections to the Hospital Relations Committee of The Council for necessary action. (Res. 97 as amended. Ref. Rept. Res.)

The House resolved that MSMS take action through its Legal Affairs Committee to declare that drug intoxication and addiction constitute a disease and should be a Medicaid benefit. (Res. 48 as amended, Ref. Rept. State & Fed. Leg.)

The House resolved that MSMS through its Legal Affairs Committee request the Legislature to approve more adequate amounts of money for approved alcohol programs. (Res. 65 as amended, Ref. Rept. State & Fed. Leg.)

The House directed that an appropriate committee of MSMS continue investigation of the Professional Liability problem and possible group coverage. (Res. 106 as amended, Ref. Rept. State & Fed. Leg.)

Matters Pertaining To Relations with Hospitals

The House requested that hospitals consider the formation of Efficiency Committees to achieve economy, efficiency and quality medical care in the hospital. (Res. 104, Ref. Rept. Pub. & Pro. Rel.)

OFFICERS OF THE COUNCIL, elected for the 1970-71 year Sept. 23 during the MSMS Annual Session, are Ross V. Taylor, M.D., chairman, center; Brooker L. Masters, M.D., vice chairman, second from right; Robert M. Leitch, M.D., Publication Committee chairman, left; Ralph R. Cooper, M.D., County Societies Committee chairman, second from left, and Ernest P. Griffin, Jr., M.D., Finance Committee chairman, right.

The House advised that hospitals discontinue using the sterilization committee procedure. (Res. 95 as amended, Ref. Rept. State & Fed. Leg.)

The House urged the Michigan Health Council and others to expand educational programs on drugs. Urged medical schools, hospitals and medical societies to establish educational programs on drug dependence. (Sub. for Res. 26 & 27, Ref. Rept. & Pro. Rel.)

The House directed The Council to exert greater efforts in joint development in planning with Michigan Hospital Association. (Res. 103, Ref. Rept. Pub. & Pro. Rel.)

The House referred Resolution 56 as amended "Disposal of Disposables" to the Public Health Committee for consideration and implementation. (Res. 56 as amended, Ref. Rept. Res.)

The House referred Resolution 51 "Formation of Michigan State Hospital Staff Association" to the Hospital Relations Committee of The Council for investigation and report to the 1971 House of Delegates. (Res. 51, Ref. Rept. Res.)

The House referred the problem of multiplicity of hospital inspections to the Hospital Relations Committee of The Council for necessary action. (Res. 97 as amended, Ref. Rept. Res.)

The House directed The Council to utilize the Socio-Economic and Hospital Relations Committee to aid the Rehabilitation Committee in forming guidelines for rehabilitative care in acute hospitals or extended care facilities. (Sub. Res. for 45 & 67, Ref. Rept. Res.)

The House supported and encouraged hospitals to provide facilities for the diagnosis, treatment and rehabilitation of patients suffering from drug dependence when feasible. (Res. 32 as amended, Ref. Rept. Misc. Bus.)

The House referred Resolution 33 to the Michigan Delegates to the AMA that the AMA direct component state and county medical societies, in cooperation with local hospital associations or groups, institute Boards of Arbitration to mediate hospital-physician disputes. (Res. 33 as amended, Ref. Rept. Pub. & Pro. Rel.)

Matters Pertaining To Miscellaneous Business

The House recognized the National Athletic Trainers Association certification procedures and certification board and urged that the Michigan State Board of Education recommend the appointment of certified athletic trainers to work with physicians in the important area of health and supervision of athletes. (Sub. Res. for 23 & 24, Ref. Rept. Misc. Bus.)

The House recommended that the annual physical examination of junior and senior high school athletes be continued and that the Michigan High School Athletic Association adopt a standard, adequate and uniform health reporting card. (Res. 17, Ref. Rept. Pub. & Pro. Rel.)

The House established guidelines for funds derived from the supervised care of staff patients. (Res. 69 as amended, Ref. Rept. Res.)

The House recognized that there are currently many acceptable methods of practicing medicine and that multiple options for the delivery of medical care should remain open to physicians. (Res. 15 as amended, Ref. Rept. Pub. & Pro. Rel.)

Annual Session Program Draws Good Comments

The annual session Symposium on Exercise was praised by Edwin G. Rice, coordinator for health education, physical education, outdoor education and recreation, for the Michigan Department of Education.

Doctor Rice pointed out that "your program was very timely and I know will prove helpful for those of us promoting improved school programs in this area. He asked that MSMS keep him posted on how "our department might implement ideas growing out of the conference."

Physician's Vote Most Important In Nov. 3 Election

Every Michigan physician is urged to study carefully the candidates for the various offices for the Nov. 3rd election.

As physicians—and as citizens—we must become involved in the election.

From the lists of candidates will come both state and national office holders who will establish the framework of virtually every facet of our individual and collective lives.

From these lists will come the individuals who will make our laws at the national level with regard to our defense systems, the quality of our environment, and the manner in which health care will be delivered to the citizens of this country.

At the state level, candidates will be involved in the making of laws that will directly affect the framework for health care delivery in Michigan and the role of the physician within this system.

Take the time now to investigate the qualifications of the candidates for Congress, for the State Legislature, for the State Board of Education, etc. If possible, meet the candidates and ask them some questions. And when you vote Nov. 3 make a careful selection—help elect those best qualified to merit your support.

CAPSULES

Donald N. Sweeny, Jr., M.D., Detroit, is a member of the AMA's new Council on Long Range Planning and Development. Doctor Sweeny, chairman of the Michigan Delegation to the AMA, will serve a three-year term on the new Council. The Council is the result of a recommendation in the so-called Himler Report and was approved by the AMA's House of Delegates at the Annual Convention in Chicago in June.

* * *

The next Michigan State Board licensure examinations will be given on Dec. 2, 3 and 4 at the Union Building, Michigan State University, East Lansing. The examination to be given will be the FLEX (Federation Licensing Examination).

* * *

"Rheumatoid Arthritis: What are the best management techniques?" is the topic of a two-day institute planned Oct. 28 and 29 at the Detroit Hilton Hotel by the Michigan Chapter of the Arthritis Foundation and by the WSU School of Medicine. The institute will help the physician who is not a specialist in arthritis improve his diagnostic skills in rheumatoid arthritis and know more about drug therapies, physical management and surgical management.

* * *

An all-day clinic for children requiring prosthetic devices is planned Nov. 4 by the Detroit Orthopaedic Clinic. The meeting is one of the semi-annual educational programs presented by the clinic which is marking its 50th year. Speaker will be Claude N. Lambert, M.D., professor of orthopaedics at the University of Illinois Research and Education Hospital, Chicago.

* * *

Chiropractors are legally physicians and the state may pay for their services under the Medicaid program, Michigan Atty. Gen. Frank Kelley ruled in mid-September. Kelley made his ruling in answer to a question from Bernard Houston, director of the State Department of Social Services.

---

michigan medicine

MICHIGAN STATE MEDICAL SOCIETY

Published semi-monthly, Trimonthly in December; 25 issues, by the Michigan State Medical Society as its official journal. Second class postage paid at East Lansing, Mich. and at additional mailing offices. Yearly subscription rate, $9.00. Printed in USA. All communications should be addressed to the Publications Committee, Michigan State Medical Society, 120 West Saginaw Street, East Lansing, Michigan 48823. © 1970 Michigan State Medical Society. Phone: Area Code 517, 337-1351.

Second Class Postage Paid at East Lansing, Mich.
and at additional mailing offices.

University of Cal.
Library Sch of Med.
Third + Parnassus A
San Francisco, Cal 94

Attention Librarians: This publication is a regular issue of MICHIGAN MEDICINE and should be saved for binding later with the larger scientific issues of the journal.

Breaking News: Deadline Oct. 26
November 1970, Volume 69, Number 21
Michigan State Medical Society

michigan medicine

Twenty-eight Michigan Medical School Faculty Members Present Fall MSMS PG Lectures

The Michigan State Medical Society is concluding 18 regional fall postgraduate programs for physicians around the state. Co-sponsors are the Michigan Department of Health, the Michigan State University College of Human Medicine, the University of Michigan Medical School and Wayne State University School of Medicine.

Speakers from Michigan State University are Charles Adams, M.D., assistant clinical professor of surgery; David S. Greenbaum, M.D., director, continuing education, and D. Bonta Hiscoe, M.D., assistant clinical professor of surgery.

On the programs from Wayne State University are Graeme Baker, M.B., Ch.B., instructor, Department of Surgery; Lawrence Power, M.D., associate professor of medicine, and Alan C. Scheer, M.D., chief, Division of Radiation Therapy.

Speakers from the University of Michigan are David G. Anderson, M.D., associate professor of obstetrics and gynecology; Joseph V. Baublis, M.D., Ph.D., associate professor of pediatrics and communicable diseases; Joseph C. Cerny, M.D., associate professor of surgery; Winthrop N. Davey, M.D., head, Medical Chest Section; Reed O. Dingman, M.D., head, plastic surgery section; Howard V. Dubin, M.D., assistant professor of dermatology; F. Bruce Fralick, M.D., professor emeritus, Department of Ophthalmology; A. James French, M.D., professor and chairman, Department of Pathology; E. Richard Harrell, M.D., chairman, Department of Dermatology; Glenn W. Kindt, M.D., associate professor of neurosurgery; George H. Koepke, M.D., professor of physical medicine

(Continued on Page 970)

A DISTINGUISHED GUEST at the 1970 MSMS Annual Session in Detroit in September was Franz J. Ingelfinger, M.D., left, editor of the esteemed **New England Journal of Medicine.** Before delivering the first MSMS Annual Discourse, Doctor Ingelfinger met over coffee with John W. Moses, M.D., center, scientific editor of **Michigan Medicine,** and Alexander J. Walt, M.D., Annual Session program chairman. Doctor Ingelfinger also met for luncheon Sept. 23 with the associate scientific editors of **Michigan Medicine.**

MSMS Honors Six Physicians With Certificates of Commendation

Six Michigan physicians outstanding in their service to medicine and their communities received the highest MSMS award in ceremonies Tuesday evening, Sept. 22, during the MSMS Annual Session in Detroit.

Receiving MSMS Certificates of Commendation from James B. Blodgett, M.D., Speaker of the MSMS House of Delegates, and Kenneth H. Johnson, M.D., MSMS secretary, were:

Hira E. Branch, M.D., Flint, "in recognition of an outstanding career in orthopedic surgery and as a proven leader in MSMS and the Genesee County Medical Society; and in appreciation of unselfish medical service to the people of South Vietnam, Indonesia, and Malaysia;"

Muir Clapper, M.D., Detroit, "in recognition of an outstanding career as an internist and as a devoted teacher at the Wayne State University School of Medicine; and in appreciation of the dedicated leadership given to the American College of Physicians in Michigan and the nation, and the American Heart Association and its Michigan chapter, and many other organizations in the fields of medicine and health education;"

Harold F. Falls, M.D., Ann Arbor, "in recognition of an outstanding career as an ophthalmologist and as a distinguished professor of ophthalmology at the University of Michigan Medical School; and also in grateful appreciation of excellent leadership to the AMA, MSMS, the Washtenaw County Medical Society, and the American Association of Ophthalmology;"

Herbert W. Harris, M.D., Lansing, "in recognition of an outstanding career in orthopedics; as a dedicated leader in Lansing and Michigan efforts to better serve crippled children; and as a medical statesman in MSMS and the Ingham County Medical Society;"

Robert E. Rice, M.D., Greenville, "in recognition of an outstanding career as a family physician and as a leader in the AMA, MSMS and the Ionia-Montcalm County Medical Society; and as a dedicated physician concerned especially about improving medical services in rural Michigan and rural America; and as an influen-

(Continued on Page 970)

Doctor Branch

Doctor Clapper

Doctor Falls

Doctor Harris

Doctor Rice

Doctor Schooten

A HAPPY MOMENT at the dedication of the nation's first medical center for black persons in Detroit recently is shared by, from left, Lionel F. Swan, M.D., president of the National Medical Association Foundation; Leslie Alexander, M.D., Brooklyn, N.Y., NMA treasurer; John A. Doherty, director of the Michigan Health Council, and Robert K. Whiteley, M.D., president of the Wayne County Medical Society. The center, located on Detroit's east side, is the first of several such facilities planned across the nation by the NMA Foundation. It will be ready in the spring.

Heads of State Mental Hospitals Named to Investigation Committee

The superintendents of five state mental hospitals have been named to review and propose changes in State Mental Health Department rules on seclusion of patients and the use of restraints.

On a committee chosen by A. Gordon Yudashkin, M.D., department director, are A. A. Birzgalis, M.D., Ionia State Hospital; J. M. Louisell, M.D., Fort Custer State Home; D. W. Martin, M.D., Pontiac State Hospital; C. M. Schrier, M.D., Kalamazoo State Hospital, and H. F. Weir, Plymouth State Home and Training School.

The review was prompted by the death in August of John Cronk, 26, a patient in the Traverse City State Hospital, while in an isolation ward.

ACP Offering Self-Assessment Test

A new opportunity for physicians to assess their own medical knowledge is available through the American College of Physicians' Second Medical Knowledge Self-Assessment program. All physicians, regardless of specialty, may obtain a prospectus by writing the ACP, Box MKSAP-11, 4200 Pine St., Philadelphia, Pa. 19104. The test, consisting of 700 questions in nine areas of general medicine, is designed to help the physician ascertain what areas of study to devote more time to.

Ecology Subject Of First National Biological Congress Nov. 6-10 in Detroit

Physicians especially interested in the ecology are cordially invited to attend the First National Biological Congress scheduled Nov. 6-10 at Cobo Hall, Detroit. The congress offers an opportunity for scientists to enter into debate with public policy makers and the public. Physicians wishing further information may contact Ann C. Barker, public information officer, American Institute of Biological Sciences, 3900 Wisconsin Ave., N.W., Washington, D.C. 20016.

Medical Assistants Plan January Seminar

"Education—Your Passport to Knowldge," is the theme of the Michigan State Medical Assistants' Mid-winter Seminar scheduled Jan. 30-31 at the Ramada Inn in Saginaw.

Speakers will include Teck Lian, M.D., Saginaw, who will discuss "The Many Faces of Drug Abuse," and William DeYoung, M.D., Saginaw, member of the MSMS Committee on Legal Affairs, whose topic will be "Forensic Medicine." Saginaw Mayor Warren Light has proclaimed Sunday, Jan. 31, as Medical Assistant Day in Saginaw.

THE THREE DEANS OF Michigan medical schools were on hand for MSMS House of Delegates proceedings Sunday during the 1970 Annual Session. At that time, they received checks representing money contributed by Michigan physicians to the AMA Education and Research Foundation. From left are Andrew D. Hunt, Jr., M.D., MSU College of Human Medicine, which received $3,475; Tommy N. Evans, M.D., WSU School of Medicine, which received $5,623 and John A. Gronvall, M.D., The U-M Medical School, which received $11,145.

WSU Symposium on Trauma Scheduled Dec. 2-3 at WCMS Headquarters

The Eighteenth Annual Symposium on Trauma will be presented Dec. 2-3 at Wayne County Medical Society Headquarters by the Michigan Committee on Trauma of the American College of Surgeons, and Wayne State University.

This year such topics as sepsis in trauma, metabolic considerations in trauma, respiratory problems in multiple injuries and vascular injuries will be discussed by a series of panels.

Among the speakers are Isidore Cohn, Jr., M.D., chairman, Department of Surgery, Louisiana State University; John A. Boswick, Jr., M.D., director, Hand Surgical Service and Burn Unit, Cook County Hospital; John H. Duff, M.D., associate professor of surgery, McGill University, Montreal; Ben Eiseman, M.D., professor of surgery, University of Colorado Medical Center; William R. Drucker, M.D., chairman, Department of Surgery, University of Toronto, and Stanley J. Dudrick, M.D., associate professor of surgery, University of Pennsylvania.

Also on the agenda are four post-graduate courses, including "Orthopedic Injuries," by Herbert E. Pedersen, M.D.; "Hand Trauma," by Joseph L. Posch, M.D.; "Plastic Surgery," by William A. Lange, M.D., and "Head and Spinal Injuries," by L. Murray Thomas, M.D.

For further information, contact Joseph L. Posch, M.D., 1408 Kales Building, Detroit 48226.

MSMS PG LECTURES/Continued

and rehabilitation; Richard O. Kraft, M.D., clinical associate professor of surgery; George W. Morley, M.D., professor of obstetrics and gynecology; Tracy A. Newkirk, M.D., instructor, Department of Neurology; William R. Olsen, M.D., associate professor of surgery; John A. Penner, M.D., associate professor of internal medicine, Hematology Section; John C. Pollard, M.D., professor of psychiatry; John F. Simpson, M.D., associate professor of neurology; James C. Sisson, M.D., associate professor of internal medicine, Nuclear Medicine Unit; Neal A. Vanselow, M.D., associate professor of internal medicine; John M. Weller, M.D., head, Renal Unit, and Walter P. Work, M.D., chairman, Department of Otorhinolaryngology.

MICHIGAN PHYSICIANS RECEIVE MSMS COMMENDATION/Continued

tial leader in school and community affairs at Greenville," and

Sarah Schooten, M.D., Detroit, "in recognition of an outstanding, long career as a pediatrician; and in grateful appreciation of your unselfish, dedicated service over many years to the St. Vincent's Sarah Fisher Home, the Salvation Army Children's Home, St. Francis Cabrini Clinic, and many other youth-serving organizations in Detroit."

MICHIGAN MEDICINE is published Semi-Monthly, Trimonthly in December; 25 issues, by the Michigan State Medical Society, 120 W. Saginaw, East Lansing, Mich. 48823. Second class postage paid at East Lansing, Mich. and at additional mailing offices.

LACTINEX®

LACTINEX

LACTINEX®

TABLETS &

GRANULES

- **to help restore and stabilize the intestinal flora**
- **for fever blisters and canker sores of herpetic origin**

Introduced to help reestablish the normal physiology of the intestinal tract in gastrointestinal disturbances[1], particularly diarrheas (including those resulting from antibiotic therapy), Lactinex is also useful for reestablishing the flora following bowel surgery, infant colic, mucous colitis, foul-smelling stools, pruritus ani, flatulence and hives.[2,3,4,5,6]

Lactinex contains a viable mixed culture of both *Lactobacillus acidophilus* and *L. bulgaricus* with the naturally occurring metabolic products produced by these organisms.

No untoward side effects have been reported to date.

Literature on indications and dosage available on request.

HYNSON, WESTCOTT & DUNNING, INC.

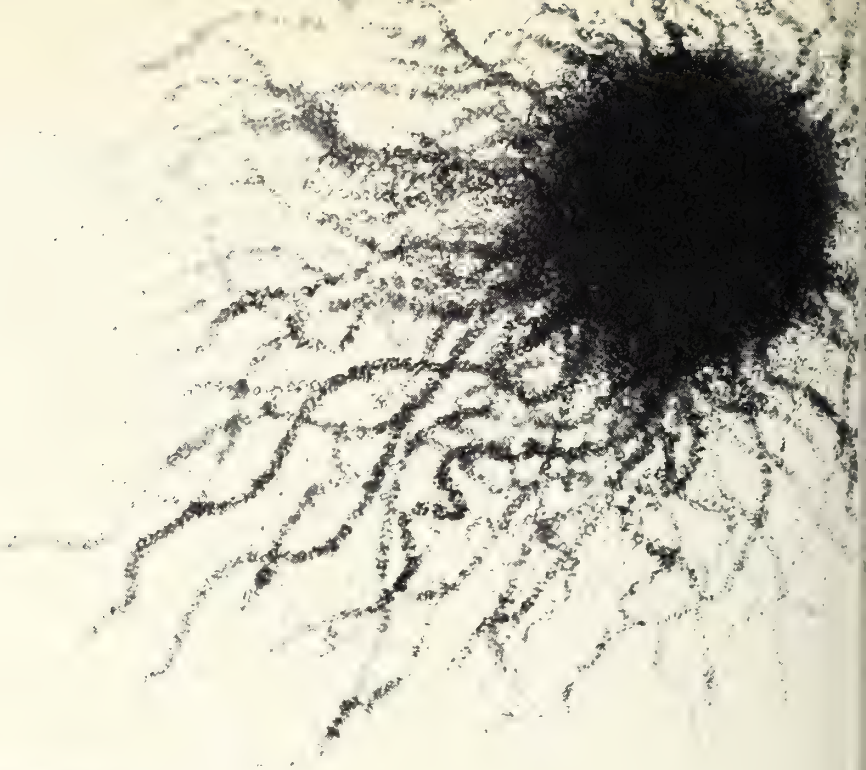
HW&D Baltimore, Maryland 21201

(#LXO6)

LX

References:

(1) Siver, R. H.: CMD, **21:**109, September 1954. (2) Frykman, H. H.: Minn. Med., **38:**19-27, January 1955. (3) McGivney, J.: Tex. State Jour. Med., **51:**16-18, January 1955. (4) Quehl, T. M.: Jour. of Florida Acad. Gen. Prac., **15:**15-16, October 1965. (5) Weekes, D. J.: NY State Jour. Med., **58:**2672-2673, August 1958. (6) Ellis, S. and Spratt, J. S.: JOUR. AMER. GER. SOC., **18:**410-415, May 1970.



Corticosteroid therapy week after week.

then antibiotic therapy last week.

and monilial overgrowth this week.

For many patients on long-term corticosteroid therapy, the addition of oral antibiotic therapy may trigger monilial overgrowth in the intestine. When you anticipate such a problem, take action with DECLOSTATIN 300. It combines the broad-spectrum potency of demethylchlortetracycline with the antifungal effectiveness of nystatin—it helps avoid monilial take-over. Experience has shown DECLOSTATIN to be highly useful for many women patients; individual culture studies will show exactly where this usefulness may best be applied.

it doesn't let monilia begin where bacteria end.

Declostatin® 300

Demethylchlortetracycline HCl 300 mg and Nystatin 500,000 units Capsule-Shaped Tablets Lederle

Effectiveness: Because its antibacterial component is DECLOMYCIN® Demethylchlortetracycline, DECLOSTATIN should be equally or more effective therapeutically than other tetracyclines in infections caused by tetracycline-sensitive organisms. The antifungal component, nystatin, protects against superinfection by antibiotic-resistant fungal overgrowth (particularly monilia) in the intestinal tract.

Contraindication: History of hypersensitivity to demethylchlortetracycline or nystatin.

Warning: In renal impairment, usual doses may lead to excessive accumulation and liver toxicity. Under such conditions, lower than usual doses are indicated and, if therapy is prolonged, serum level determinations may be advisable. A photodynamic reaction to natural or artificial sunlight has been observed. Small amounts of drug and short exposure may produce an exaggerated sunburn reaction which may range from erythema to severe skin manifestations. In a smaller proportion, photoallergic reactions have been reported. Patients should avoid direct exposure to sunlight and discontinue drug at the first evidence of skin discomfort. Necessary subsequent courses of treatment with tetracyclines should be carefully observed.

Precautions: Overgrowth of nonsusceptible organisms may occur. Constant observation is essential. If new infections appear, appropriate measures should be taken. In infants, increased intracranial pressure with bulging fontanels has been observed. All signs and symptoms have disappeared rapidly upon cessation of treatment.

Side Effects: Gastrointestinal system—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. Skin—maculopapular and erythematous rashes; a rare case of exfoliative dermatitis has been reported. Photosensitivity; onycholysis and discoloration of the nails (rare). Kidney—rise in BUN, apparently dose-related. Transient, reversible, nephrogenic diabetes insipidus with excessive thirst and polyuria (rare). Hypersensitivity reactions—urticaria, angioneurotic edema, anaphylaxis. Teeth—dental staining (yellow-brown) in children of mothers given this drug during the latter half of pregnancy, and in children given the drug during the neonatal period, infancy and early childhood. Enamel hypoplasia has been seen in a few children. If adverse reaction or idiosyncrasy occurs, discontinue medication and institute appropriate therapy. Demethylchlortetracycline may form a stable calcium complex in any bone-forming tissue with no serious harmful effects reported thus far in humans.

Average Adult Daily Dosage: One tablet b.i.d. Should be given 1 hour before or 2 hours after meals, since absorption is impaired by the concomitant administration of high calcium content drugs, foods and some dairy products. Treatment of streptococcal infections should continue for 10 days, even though symptoms have subsided.

Lederle LEDERLE LABORATORIES, A Division of American Cyanamid Company, Pearl River, New York 448-9

michigan medicine

SCIENTIFIC EDITOR
John W. Moses, MD

EXECUTIVE EDITOR
Herbert A. Auer

MANAGING EDITOR
Judith Marr

ASSOCIATE SCIENTIFIC EDITORS
Jason Bodzin, MD
Detroit, House Staff
Frederick J. Cady, Jr., MD
Saginaw, Surgery
Robert M. Daugherty, MD
East Lansing, Basic Science
Harold E. DePree, MD
Kalamazoo, Medicine
Dean C. Elliott, MD
Petoskey, Otolaryngology
Tommy N. Evans, MD
Detroit, Obst.-Gyn.
E. Richard Harrell, MD
Ann Arbor, Dermatology
Dorin L. Hinerman, MD
Ann Arbor, Pathology
Samuel D. Jacobson, MD
Detroit, Medicine
Benjamin Jeffries, MD
Detroit, Psychiatry
Raymond S. Kurtzman, MD
Detroit, Radiology
A. Martin Lerner, MD
Detroit, Medicine
John C. Peirce, MD
Grand Rapids, Medicine
Frank H. Power, MD
Traverse City, Surgery
J. G. Turcotte, MD
Ann Arbor, Surgery
Alexander J. Walt, MD
Detroit, Surgery
Park W. Willis, III, MD
Ann Arbor, Medicine
Richard E. Wunsch, MD
Traverse City, Medicine

PUBLICATION COMMITTEE
Robert M. Leitch, MD
Chairman

MICHIGAN MEDICINE is the official organ of the Michigan State Medical Society, published under the direction of the Publication Committee. Published Semi-Monthly, Trimonthly in December; 25 issues, by the Michigan State Medical Society as its official journal. Second class postage paid at East Lansing, Mich. and at additional mailing offices. Yearly subscription rate, $9.00; single copies, 80 cents. Additional postage: Canada, $1.00 per year; Pan-American Union, $2.50 per year; Foreign, $2.50 per year. Printed in USA. All communications relative to manuscripts, advertising, news, exchanges, etc., should be addressed to Publication Committee, Michigan State Medical Society, 120 West Saginaw Street, East Lansing, Michigan 48823. Phone Area Code 517, 337-1351. © 1970 Michigan State Medical Society.

* * *

MICHIGAN MEDICINE welcomes original scientific manuscripts, news items, photographs, features and letters presenting comments on issues. Authors may write to the MSMS Headquarters to obtain detailed instructions for the preparation of scientific papers.

IN THIS ISSUE

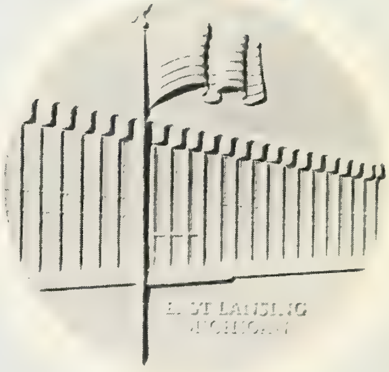
SCIENTIFIC ARTICLES

981 The Michigan Physician and His Continuing Education; Floyd C. Mann, Ph.D.; John Kotre, Ph.D.; Anthony Reilly, Ph.D.; Neal A. Vanselow, M.D.

991 Non-invasive Approaches to Cardiac, Vascular, and Pulmonary Dynamics; Jan Nyboer, D.Sc., M.D.

OTHER FEATURES

967 Breaking News
974 your opinion please
976 msms leadership
977 officers' page
978 msms news
mediscene
979 council minutes
1001 editorial viewpoints
1002 mailbag
monthly surveillance report
1010 environment and health
1017 about doctors
1023 medical care programs
1028 county societies
1030 ancillary
1039 in memoriam
1046 noted and quoted



MICHIGAN STATE MEDICAL SOCIETY
120 West Saginaw (P.O. Box 152)
East Lansing, Mich. 48823
Area Code 517, 337-1351

your opinion please

Suggest one way that you feel county medical societies could change their operations to become more relevant to the needs, problems and opportunities of their members.

Joseph R. Cipparone, M.D.
Saginaw

One way that I feel county medical societies could change their operations to become more relevant to the needs, problems and opportunities of their members would be to have better communications with medical students, interns and residents concerning the purpose, operation and activities of the medical societies. The 1968 House of Delegates of M.S.M.S. adopted Resolution 53 which dealt with liaison with medical students, interns and residents. The resolveds were (1) that M.S.M.S. institute a program whereby medical students and interns may assume an affiliate membership with the local medical society in Michigan without all the rights and privileges of the local society and (2) that a similar resolution be presented to the A.M.A. House of Delegates by the delegates from M.S.M.S. at the earliest opportunity.

In interviewing a number of medical students I have been informed as of August 1970 that they have not as yet been offered an affiliate membership in their local medical society. Two years have elapsed with no action. It is no wonder that our graduates leave Michigan to train elsewhere while we form new committees to ascertain that they are leaving the state in such large numbers.

The old adage that prophylaxis is better than cure still is as true today as it ever was. "Generation gap" attitudes and protests which are beginning to appear among medical students in this country do not "just happen."

The rapidity of change in the nature and duration of graduate medical education makes it mandatory that we have better communications with the medical students and house staff physicians if we are to encourage these individuals to practice in this state. Since medical students in particular are taking their training in diverse hospitals throughout the state, the local county medical societies would do well to form "medical student liaison committees" to relate to them the purpose, operation and activities of their respective societies. Greater hospitality may pay off in greater numbers of young doctors remaining to practice in this state.

"Your opinion please" is a monthly feature in *Michigan Medicine* designed to provide a forum for the views of Michigan physicians on vital issues. Your comments are invited in response to the questions asked on these pages.

A topic is selected each month and interested physicians are urged to send in their reactions. Letters in response to the subject for the January issue must be received in the MSMS office by Dec. 1.

The January question will be: "How can physicians—especially young physicians—be encouraged to practice in the inner city or in rural areas?"

H. Richard Henderson, M.D.
Farmington

My suggestion would be to call for a constitutional convention with the intent of reviewing and rewriting the constitution and its by-laws so that county medical societies can operate with relevance to the needs, problems and opportunities of *all* their members. This would require a leadership which, first, believes it is not relevant and, second, is willing to undergo critical and constructive self-analysis. It would require a membership which believes that the time and effort it puts into society functions is important.

I would further suggest there is a need for a change in county medical society philosophy. The county society operates primarily through committee action. Committees should function with a purpose of actively assuming responsibility and leadership. In other words, they should get involved! This takes time and dedication and, in certain circumstances, a stipend for services rendered may be entirely appropriate.

The AMA has the tradition, the basic organization and the financial strength to be the profession's most relevant spokesman. It needs 100% participation but it requires responsive and representative leadership.

Fast...long-lasting relief of aches and pains of colds and flu

with the unique timed-release aspirin

Double strength Measurin timed-release aspirin offers a new kind of control for your patients with cold and flu discomforts. In each 10-grain tablet are over 6,000 microscopic reservoirs that release aspirin at a controlled rate—some right away and some later on. This means fast relief of symptoms, followed by hours of comfort. Throughout the day, Measurin gives your patients freedom from a 4-hour aspirin schedule. During the night, its 8-hour dosage schedule holds the promise of sound sleep without awakening to take extra tablets.

For Professional Samples write:
Breon Laboratories Inc.
Sample Fulfillment Division
P.O. Box 141
Fairview, N.J. 07022

BREON **BREON LABORATORIES INC.**
90 Park Avenue, New York, N.Y. 10016
Subsidiary of Sterling Drug Inc.

MEASURIN®
TIMED-RELEASE ASPIRIN

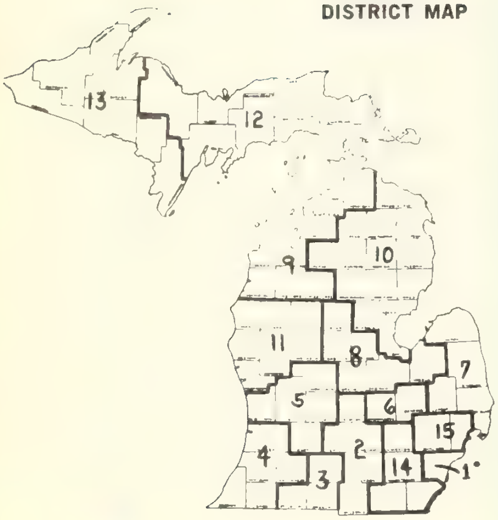
ECONOMICAL • EFFECTIVE • LONG LASTING PAIN RELIEF

Dosage: 2 tablets followed by 1 or 2 tablets every 8 hours as required, not to exceed 6 tablets in 24 hours. For maximum nighttime pain relief, 2 tablets at bedtime.
Available: Bottles of 12, 36 and 60 tablets.

msms leadership

PRESIDENT	Harold H. Hiscock, M.D.	Flint
PRESIDENT-ELECT	Sidney Adler, M.D.	Detroit
SECRETARY	Kenneth H. Johnson, M.D.	Lansing
ASST. SECRETARY	Brooker L. Masters, M.D.	Fremont
TREASURER	John R. Ylvisaker, M.D.	Pontiac
ASST. TREASURER	C. Allen Payne, M.D.	Gd. Rapids
SPEAKER	Vernon V. Bass, M.D.	Saginaw
VICE-SPEAKER	James D. Fryfogle, M.D.	Detroit
PAST PRESIDENT	Robert J. Mason, M.D.	Birmingham
COUNCIL CHR.	Ross V. Taylor, M.D.	Jackson
VICE-CHAIRMAN	Brooker L. Masters, M.D.	Fremont

COUNCILOR
DISTRICT MAP



First District Councilors: (Wayne County)
Edward J. Tallant, MD, Detroit
Ralph R. Cooper, MD, Detroit
Frank G. Bicknell, MD, Detroit
Milton R. Weed, MD, Grosse Pointe Park
Brock E. Brush, MD, Detroit

Second District Councilor: Ross V. Taylor, MD, Jackson
Counties: Clinton, Eaton, Hillsdale, Ingham, Jackson

Third District Councilor: Robert M. Leitch, MD, Union City
Counties: Branch, Calhoun, St. Joseph

Fourth District Councilor: W. Kaye Locklin, MD, Kalamazoo
Counties: Allegan, Berrien, Cass, Kalamazoo, Van Buren

Fifth District Councilor: Noyes L. Avery, MD, Grand Rapids
Counties: Barry, Ionia-Montcalm, Kent, Ottawa

Sixth District Councilor: Ernest P. Griffin, Jr., MD, Flint
Counties: Genesee, Shiawassee

Seventh District Councilor: John J. Coury, MD, Port Huron
Counties: Huron, Sanilac, Lapeer, St. Clair

Eighth District Councilor: A. Carl Stander, MD, Saginaw
Counties: Gratiot-Isabella-Clare, Midland, Saginaw, Tuscola

Ninth District Councilor: Adam C. McClay, MD, Traverse City
Counties: Grand Traverse-Leelanau-Benzie, Manistee, Northern Michigan (Antrim, Charlevoix, Cheboygan and Emmet combined), Wexford-Missaukee

Tenth District Councilor: Robert C. Prophater, MD, Bay City
Counties: Alpena-Alcona-Presque Isle, Bay-Arenac-Iosco, North Central Counties (Otsego, Montmorency, Crawford, Oscoda, Roscommon, Ogemaw, Gladwin and Kalkaska, combined)

Eleventh District Councilor: Brooker L. Masters, MD, Fremont
Counties: Mason, Mecosta-Osceola-Lake, Muskegon, Newaygo, Oceana

Twelfth District Councilor: William A. LeMire, Sr., MD, Escanaba
Counties: Chippewa-Mackinac, Delta-Schoolcraft, Luce, Marquette-Alger

Thirteenth District Councilor: Donald T. Anderson, MD, Wakefield
Counties: Dickinson-Iron, Gogebic, Houghton-Baraga-Keweenaw, Menominee, Ontonagon

Fourteenth District Councilor: Donato F. Sarapo, MD, Ann Arbor
Counties: Lenawee, Livingston, Monroe, Washtenaw

Fifteenth District Councilor: Sydney Scher, MD, Mount Clemens
Counties: Macomb, Oakland

DIRECTOR
Warren F. Tryloff..........East Lansing

GENERAL COUNSEL
Lester P. Dodd.................Detroit

LEGAL COUNSEL
A. Stewart Kerr ....Detroit

ECON. CONSULTANT
Clyde T. Hardwick ....Houghton

HISTORIAN
Wm. J. Stapleton, Jr., MD........Detroit

ASS'T HISTORIAN
Wm. M. LeFevre, MD.........Muskegon

SCIENTIFIC EDITOR
John W. Moses, MD............Detroit

Deliberate Follow-up Action Now Needed On MSMS House-Passed Resolutions

The MSMS House of Delegates in Detroit approved many resolutions and these soon will be included in the proceedings which will be mailed to all members.

Passing resolutions is the best way to develop policy positions on issues. MSMS has done this for many years and surely we will have many more resolutions before the 1971 House of Delegates in Grand Rapids, October 3-4-5.

> *Let me point out that it is the action by the members following the spirit of the resolutions that solves most of the problems faced by physicians and medical societies, not just the mere passage of resolutions written on paper.*

Just passing resolutions alone will not change situations. The House of Delegates passed several resolutions, for instance, that suggested changes in state or federal legislation. Now that a policy position has been defined or redefined, MSMS officers, committees and staff members must work to bring about the desired changes. You must help.

Some resolutions suggested public-service projects that MSMS and its members might carry out. The staff and MSMS chairmen will offer guidance and suggestions, but again it will be the individual members and component societies that must act.

Sending copies of resolutions to different leaders and organizations is another futile action unless members are willing to work personally with congressmen, legislators, educators, etc., to bring about desired programs or suggested changes. Sending copies of resolutions might be compared with waving a wand unless there is deliberate follow-up action.

Personally, I am glad that the delegates want The MSMS Council to continue the Councilor District Conferences that are held each August and September before the Annual House of Delegates meeting. These provide the opportunity to discuss some of the issues, to read some of the early resolutions, to involve the component society officers in debate, etc. Without these meetings first, the delegates would be expected in slightly more than two days at their meeting to study issues in detail and to adopt major policy positions.

> *The House often exercises proper caution, too, by recommending that a study committee explore some suggested policy change and come back to the next session with its recommendations, so snap decisions can be minimized.*

MSMS members owe much gratitude to members of the MSMS House of Delegates for their contributions during the House meeting and also for many hours spent throughout the year digging deep into problems and considering alternative solutions.

Harold H. Hiscock, M.D.
MSMS President

msms news

Michigan Mediscene

Nov. 4—Detroit Orthopaedic Clinic, all-day meeting for children requiring prosthetic devices, led by Claude N. Lambert, M.D., professor of orthopedics at the University of Illinois Research and Education Hospital
Nov. 4—Special meeting of The Council, MSMS Headquarters, noon
Nov. 6—First National Biological Congress, "Man and Environment," Cobo Hall, Detroit
Nov. 9-13—International Drug Abuse Symposium, Towsley Center, U-M, Ann Arbor
Nov. 11—Michigan Cancer Coordinating Committee, MSMS Headquarters, noon
Nov. 15-21—National Diabetes Detection Week
Nov. 18—MSMS Board of Managers
Nov. 22—Board meeting, Michigan State Medical Assistants Society, MSMS Headquarters, 11 a.m.
Nov. 29-Dec. 2—Many Michigan physicians will participate in the annual AMA Clinical Convention in Boston
Dec. 2-3—18th Annual Trauma Day, Wayne County Medical Headquarters, Detroit
Dec. 2-4—Michigan State Board Examinations, Union Building, Michigan State University, East Lansing
Dec. 9—MSMS Council, MSMS Headquarters, 9:30 a.m.
Dec. 9—10th Annual Wayne State University Thyroid Workshop, Wayne County Medical Society Auditorium, Detroit
Jan. 26—Board Meeting, Woman's Auxiliary to MSMS, MSMS Headquarters, East Lansing
Jan. 30-31—Annual Winter Educational Seminar, Michigan State Medical Assistants Society, The Ramada Inn, Saginaw
April 22—Sixth Annual MSMS Conference on Medical Aspects of High School Sports, Kellogg Center, MSU, East Lansing
April 29-May 1—Annual Scientific Sessions and Heart Days, Michigan Heart Association, Cobo Hall and the Pontchartrain Hotel, Detroit
April 30-May 2—Annual Meeting, Michigan State Medical Assistants Society, Weber's Motor Inn, Ann Arbor
May 9-15—Michigan Hospital Week

The News Media Ask these Questions Most Often

MSMS members will be interested in the answers to the several questions that are asked most often by members of the press, radio and TV:

* * *

Question: What is the current shortage of physicians in the nation?

Answer: HEW places the shortage at 52,000. The AMA will no longer make such an estimate because of all the variables.

* * *

Question: What is the current shortage of physicians in Michigan?

Answer: The Michigan Health Council, and its Doctor Placement Service, estimates the need at more than 2,000.

* * *

Question: How many medical schools are there in the nation today?

Answer: There are 103 medical schools today, a sharp increase from the 72 at the end of World War II, with more scheduled to open in the next several years.

* * *

Question: What is the ratio of physicians per 100,000 population in the nation?

Answer: HEW in its 1969 issue of *Health Resources Statistics* reports the number of MDs and DOs per 100,000 total population was 158 in 1967. It had been 149 from 1950 through 1963. HEW reports there were 305,453 active doctors and osteopaths in 1967, the last official count.

* * *

Question: What is the ratio in Michigan?

Answer: The HEW publication reports in 1967 there were 12,541 active MDs and DOs for a ratio of 146 physicians per 100,000 population.

The October Journal . . .

featured important articles on the mercury contamination of fish and its effect on human health, on the care of stroke patients, on the Society of Pediatric Research, the American Psychiatric Association and the Third National Cancer Survey. Be sure to read them, Doctor.

council minutes

Extract of Minutes of MSMS Council Meeting of Sept. 20 and 23

MSMS Counseling Service Proposed

MSMS SERVICE—The Council eceived for information only the ecommendation of the Committee n Medical Socio-Economics that a ounseling and negotiating service e established to include a reearch librarian, computer prorammer, economist, attorney, one r two secretaries and adequate ffice space and equipment, to be unded by a dues increase adeuate to cover the estimated costs f $150,000 annually.

(The recommendation subseuently was the subject of several esolutions introduced at the 1970 ouse of Delegates.)

NATIONAL MEETINGS—The ouncil authorized Harry A. Towsley, M.D., chairman, MSMS ommittee on Postgraduate Medial Education, and MSMS Staff member Miss Helen Schulte to atend the Second National Confernce of State Medical Association epresentatives on Continuing Education, Chicago, Oct. 13-15. The ouncil authorized Warren F. Tryoff, MSMS Director, and Herbert A. Auer, manager, MSMS commuications department, to attend he Conference on Health Quackry-Chiropractic, in Boston, Nov. 9.

TASK FORCE REPORT—The ouncil received the MSMS Task orce's report on the feasibility of iscontinuing MSMS's historical elationship with Michigan Medial Service, and transmitted the reort to the MSMS House of Repesentatives.

RETIRING COUNCILORS—ouncil Chairman Ross V. Taylor, M.D., presented framed awards to etiring councilors and officers for heir contributions to MSMS. The wards went to Harold F. Falls, M.D., Ann Arbor; John R. Franck, Jr., M.D., Wakefield; Don Marshall, M.D., Kalamazoo; John R. Pedden, M.D., Grand Rapids; Robert K. Whiteley, M.D., Detroit; Don W. McLean, M.D., Detroit, and James J. Lightbody, M.D., Detroit.

COUNCILOR CONFERENCES—The Council reviewed the 1970 series of the MSMS Councilor Conferences and recommended to the House of Delegates that such conferences be continued.

MHS ADVISORY COMMITTEE—The Council voted that Frank Walker, M.D., or Louis Zako, M.D., or both, be nominated to fill a vacancy on the Michigan Hospital Service Medical Advisory Committee left by the resignation of William LeFevre, M.D., North Muskegon.

MATERNAL WELFARE CONFERENCE—The Council received a letter from the Clara Elizabeth Fund of Flint notifying MSMS of the Fund's inability to finance future Conferences. MSMS is looking for other sources of funding.

MIDSUMMER MEETING—The Council reviewed its annual three-day midsummer meetings and the possibility of condensing them into one-day meetings, but voted to continue them as three-day meetings.

HEADQUARTERS SECURITY—The Council recommended that lights at the MSMS Headquarters building, both interior and exterior, be left on throughout the hours of darkness, and that staff investigate the possibility of installing sonar equipment to detect persons breaking and entering, to replace the guard now hired.

STUDENT AID—The Council approved the County Societies Committee's recommendation that the deans of the three medical schools prepare a document defining the problem of medical student finances and send it to component medical societies so they can develop programs of credit support and loans to help the students.

LEGISLATION—The Council approved the Committee on Professional Insurance's recommendation that The Council continue its efforts in future legislative sessions to effect passage of the important bills about revising the statute of limitations, separate trial for statute of limitations, filing of security by plaintiff and payment of damages by insurer not construed as admission of liability.

HIGHWAY INJURY—The Council decided to refer back to the Committee on Highway Injury a recommendation that insurance companies provide ambulance service as a benefit to their subscribers and that the Committee be authorized to solicit support of this recommendation from other professional organizations concerned with emergency health care. The committee was instructed to explore the possibility of this benefit being added to automobile insurance policies rather than prepaid health insurance policies.

MESH—The Council appointed Paul W. Gikas, M.D., chairman of the MSMS Committee on Highway Injury, to represent MSMS on the Medical Emergency Services Health Council.

STATE COMMISSION—The Council approved the recommendation of the State Comprehensive Health Planning Advisory Council to abolish the State Comprehensive Health Planning Commission.

PINT (473 cc) M-148
Lilly
ILOSONE® LIQUID
125
Lilly
ILOSONE® LIQUID
250
Lilly
ILOSONE®
Lilly
ILOSONE®
125 mg
Lilly
ILOSONE®
250 mg

Each 5 cc. contain
erythromycin estolate
equivalent to 250 mg.
erythromycin base.

When mixed as directed,
each 5 cc. will contain erythromycin
estolate equivalent to 125 mg.
erythromycin base.

When mixed as
directed, each cc.
will contain
erythromycin estolate
equivalent to 100 mg.
erythromycin base.

Each 5 cc. contain
erythromycin estolate
equivalent to 125 mg
erythromycin base.

Each tablet contains
erythromycin estolate
equivalent to 125 mg.
erythromycin base.

The many forms of Ilosone®

Erythromycin Estolate

Each Pulvule® contains
erythromycin estolate
equivalent to 125 mg.
erythromycin base.

Each Pulvule contains
erythromycin estolate
equivalent to 250 mg.
erythromycin base.

Lilly

Additional information
available upon request.
Eli Lilly and Company
Indianapolis, Indiana 46206

The Michigan Physician And His Continuing Education

MARMP Study Purpose, Design and First Findings

By Floyd C. Mann, Ph.D.
John Kotre, Ph.D.
Anthony Reilly, Ph.D.
Neal A. Vanselow, M.D.
Ann Arbor

This is the first of several articles that will report the principal findings from a study concerned with the continuing education of practicing physicians in the State of Michigan.

The idea that led to the study originated in a discussion of the Committee on Post Graduate Education of the Michigan State Medical Society.[1] The study was supported by a grant from the Michigan Association of Regional Medical Programs.[2] The research is being done by a team of organizational psychologists and physicians who have the long range goal of strengthening the present processes of educational self-renewal and growth that are effective, and of developing additional educational programs and activities to meet the continually augmenting needs for new knowledge experienced by physicians.

The study is a multiple phased operation that was begun in the fall of 1968. The first phase was a survey of the attitudes and opinions of physicians regarding continuing education; the second was designed to identify the more active and influential physicians in the formal and informal information exchange systems that exist within medical staffs and to learn what distinguished these men from their colleagues. Findings from the first phase of our work will be presented in this series of articles.

The principal objectives of the first phase were:

1) to determine how physicians keep up-to-date medically,

2) to assess how physicians evaluate continuing education activities and programs currently offered,

3) to learn what kinds of continuing education needs physicians have,

4) to identify some of the situational and motivational forces that stimulate or inhibit professional growth, and

5) to see if more competent physicians use and evaluate continuing education differently than physicians in general.

To meet these objectives, a survey research design was developed that would allow the study team to compare the responses given by four different groups of physicians to an extensive paper and pencil questionnaire. The four groups were: doctors of medicine, doctors of osteopathy, doctors' doctors, and doctors with whom physicians consulted informally and formally. We will describe

The principal investigator for this study was Floyd Mann, Ph.D. Anthony Reilly, Ph.D., and William Morris, Ph.D. were responsible for the direction of the project on a day to day basis. Neal Vanselow, M.D. collaborated with this team in the design and review of the work throughout the project. John Kotre, Ph.D. joined the study team after the data were collected, and has contributed to the analysis and write-up of the findings. Doctor Mann, Doctor Reilly, Doctor Morris and Doctor Kotre are of the Center for Research on Utilization of Scientific Knowledge, and Doctor Vanselow is with the Department of Post Graduate Medicine, The University of Michigan.

scientific papers

---

[1] The members of this Committee at that time included the following physicians: H. A. Towsley, M.D., Chairman, J. R. Heidenreich, M.D., Vice Chairman, R. J. Bing, M.D., J. S. Dooley, M.D., R. W. Emerick, M.D., O. K. Engelke, M.D., T. N. Evans, M.D., E. D. Gardner, M.D., A. M. Learner, M.D., D. S. MacIntyre, M.D., R. M. Stow, M.D., N. A. Vanselow, M.D., A. J. Walt, M. D., S. B. Winslow, M.D.

[2] This research was supported by the Michigan Association for Regional Medical Programs, Contract Number 69-5-23.

first the four groups of physicians and then the questionnaire employed in the study.

The Four Major Groups

The samples of respondents for the first two groups (MD's and DO's) were selected by procedures appropriate to ensure representativeness of these two populations of practicing physicians in the state as a whole. Current lists of licensed practicing physicians, provided by the State Health Department, were used in this process. Included in these random samples were physicians engaged in full time general practice, or full time specialty private practice, and full time staff physicians who worked in a hospital setting, but did not engage in private practice. Eliminated from the populations from which the samples were chosen were: interns and residents; full time medical school faculty; any physician listed in the Federal Services Section of the American Medical Directory; research physicians; physicians serving in administrative medicine positions; and retired physicians.

The other two groups—the doctors' doctors and the informal/formal consultants—were purposive samples selected through interviews with half of the physicians in the active medical staffs of the 21 hospitals used in the second phase of the study. In these interviews each physician was asked to name physicians in the hospital of his major affiliation to whom he would go, or to whom he would send members of his family for particular kinds of medical attention. These peer-nominated physicians whom physicians would select as their own personal physician were designated as doctors' doctors—if the nominee was at least one standard deviation above the mean number of nominations in their particular specialty in their respective hospital.

During each interview each physician was also asked first to name the three physicians in his hospital with whom he most often discussed cases informally during the course of an ordinary week, and then to indicate the three on whom he typically called for formal consultations. Those physicians who received two or more nominations as persons who were consulted both informally or formally were designated as informal/formal consultants in the medical staff.

These two groups—the doctors' doctors and the consultants—constitute the two criterion groups for the first phase of the study—the physicians whom other physicians recognized as having high medical-technical competence. The inclusion of these two groups of more highly competent physicians added analytical power to our study and opened the possibility of having the study be something more than just another survey of the continuing education needs of physicians.

By comparing the response patterns of the more competent physicians in our purposive samples with those of the physicians in our representative samples of MD's and DO's in the state as a whole, it was hoped that we could obtain leads that might be used eventually to improve continuing education for all physicians. If highly competent physicians reported using some means of keeping up-to-date more frequently and valued it a good deal more than physicians in general, such a finding might suggest new ways of strengthening continuing education for physicians in general.

At the very least the inclusion of the criterion groups would indicate the extent to which different groups of physicians ought to have continuing activities tailored to their special needs. The continuing education needs of the physicians who are acknowledged to have key roles in the knowledge flow system are particularly important; these are the few that the many rely on to have the right information available for immediate recall as it is needed.

The Questionnaire

Before turning from the study design to look at a few of the findings that introduce the reader to the type of data obtained in this study, a few words need to be said about the paper and pencil questionnaire, its construction, and administration. Previous studies of physicians' opinions about different kinds of continuing education activities were reviewed. A small advisory committee of physicians[3] was asked for their ideas and suggestions regarding the types of questions to be included. Many questions were specifically designed for the study; others were adapted from earlier research in the Institute for Social Research in which movivations, job needs and opportunities, worries and concerns of other types of professionals had been studied in detail. Several pre-tests of the questionnaire were made with the help of a number of physicians; the instrument went through three revisions.

The final version had a half dozen major groupings of questions. These dealt with physicians' involvement in continuing education activities—journal reading, attendance at professional meetings, post graduate courses; physicians' evaluation of present C/E programs; their perceived needs regarding specific types of C/E activities; the factors that motivate and provide professional stimulation to physicians; their work pressures, bothers,

---

[3] This group consisted of Myron S. Magen, D.O., Medical Director of Botsford General Hospital, John Moses, M.D., Director of Medical Education, Mount Carmel Mercy Hospital; C. Allen Payne, M.D., Past President of Michigan Medical Society; Irwin J. Schatz, M.D., Director of Post Graduate Medicine, Wayne State University, and Ronald Richards, Ph.D., MARMP.

Table 1

Key Background Information on Participating Michigan Physicians

	Medical Doctors	Doctors of Osteopathy	Doctors' Doctors	Informal/Formal Consultants
Percent specialists	72	32	96	91
Percent board certified	48	21	83	73
Percent with three or more years of residency training	59	16	76	81
Percent in solo practice	52	56	43	44
Percent affiliated with hospitals of 300 or more beds	54	16	45	49
Percent in southeast Michigan[1]	58	56	44	49
Percent over 55	33	14	11	12
N =	919	183	96	89

Note: In the case of each variable, the percentage of doctors of osteopathy, doctors' doctors, and consultants is significantly different from the percentage of medical doctors at the .01 level (X^2 or t test).

---

[1] Michigan was divided into six geographical regions for purposes of sampling and analysis. The southeast section included Detroit (and Wayne State University) and Ann Arbor (and the University of Michigan).

and worries; their perceptions of their own competences and vulnerability to obsolescence; and personal and background information regarding specialty, certification, type of practice, and size of hospital of major affiliation.

In early March 1969 a letter was sent to more than 1,600 physicians in our probability samples informing them of the study and enlisting their cooperation to participate. Sixteen hundred and eight questionnaires were mailed March 18. Two out of every three physicians practicing in the upper peninsula and in the upper area of the lower peninsula, and one out of every six physicians in the rest of the state were sent questionnaires. Slightly different forms were used for MD's and DO's, with different letters of introduction indicating that the two parent associations had approved the project and were asking their membership to complete the questionnaire. The questionnaires were anonymous, but each physician was given a postcard to mail separately to let us know when he had filled out the questionnaire and mailed it.

A follow-up postcard to all who had not returned their cards was sent about four weeks after the first mailing. The postcard had a return detachable section on which the physician merely had to sign his name and check one of three boxes to indicate (1) if he had the questionnaire and would mail it, (2) the questionnaire was misplaced and another should be sent, or (3) it had been filled out and returned. Six weeks later a second questionnaire and letter were sent to all non-respondents. This was followed by personal telephone calls to those from whom we had not heard after several tries.

Responses, or information concerning the physicians, were received from 1422 individuals or 88.4 percent of the total sample. 1,102 or 68.5 percent of the questionnaires were completed and returned, 919 from MD's and 183 from DO's. Our information regarding the others was that from one to three percent had moved from the state, had retired, were too ill to participate, had died, were in the military service, were not in full time practice, or had no telephone listing during this period of intensive follow-up. Since these were not unlisted numbers, these also were assumed to have moved from the community. Two percent returned the questionnaire without filling it out, but gave no reason; 4.3 percent refused to participate; no response of any kind was received from 11.6 percent by the cut-off date we had set for accepting completed questionnaires.

Results: Background Characteristics

Table 1 presents background information on participants in this study. Doctors of osteopathy and physicians in the two criterion samples differed significantly from the general sample of medical doctors on all of these background characteristics.

The general sample of MD's was comprised mainly of specialists (72 percent). Nearly half the MD's (48 percent) said they were board certified and 59 percent had at least three years of residency training. The majority of MD's were in solo

Table 2

9. On the average, how many hours do you work per week? (Including patient care, reading, teaching, etc.)

PERCENT responding:	Medical Doctors		Doctors of Osteopathy		Doctors' Doctors		Informal/Formal Consultants	
(1) Under 40 hours	8	35	9	38	0	13	1	6
(2) 41-45 hours	12		12		3		3	
(3) 46-50 hours	15		17		10		2	
(4) 51-55 hours	15		14		17		18	
(5) 56-60 hours	20	49	18	47	27	70	28	76
(6) 61-65 hours	14		10		20		23	
(7) 66-70 hours	8		8		14		14	
(8) Over 70 hours	7		11		9		11	
No Response	1		1		0		0	
	100		100		100		100	
N =	919		183		96		89	
Mean Category No. =	4.40		4.34		5.28**		5.46**	
Std. Dev. =	1.95		2.09		1.55		1.53	

**The mean of this distribution is significantly different from the mean of the medical doctors' distribution at the .01 level (t-test, 2-tailed).

practice (52 percent), affiliated with hospitals of 300 or more beds (54 percent), and located in the southeastern part of the state (58 percent). One-third of these doctors (33 percent) were over the age of 55.

Fewer DO's (32 percent) than MD's were specialists and fewer reported they were board certified (21 percent) or that they had three or more years of residency training (16 percent). More osteopaths (56 percent) than medical doctors were in solo practice, more (20 percent—not shown in Table 1) in two-man partnerships, and fewer (8 percent—not shown in Table 1) in institutional settings. Fewer DO's (16 percent) than MD's were affiliated with hospitals as large as 300 beds. Approximately the same proportion of DO's as MD's (56 percent) practiced in southeastern Michigan; a greater proportion of DO's (17 percent—not shown in Table 1) were located in east central Michigan; and fewer (0.5 percent—not shown in Table 1) practiced in the upper peninsula. As a group, osteopathic physicians were younger than medical doctors, only 14 percent of them being over 55.

More doctors' doctors (96 percent) and informal/formal consultants (91 percent) than medical doctors were specialists. More (83 and 73 percent respectively) were board certified and more (76 and 81 percent) had completed at least three years of residency training. Fewer of these criterion physicians were in solo practice (43 and 44 percent); more (56 and 51 percent—not shown in Table 1) practiced in two-man or group settings; and fewer (1 and 5 percent—not shown in Table 1) had institutional practices. A smaller proportion of criterion doctors (45 and 49 percent) than MD's were affiliated with hospitals of 300 or more beds and fewer (44 and 49 percent) practiced in the southeast section of the state. Doctors' doctors and informal/formal consultants were also younger than medical doctors: only 11 and 12 percent respectively were over 55.

Hours Worked Per Week

Central to any understanding of the problems facing continuing medical education is an understanding of the work load of the physicians involved. Early in the questionnaire we inquired about the length in hours of the physician's work week. In estimating their work loads, respondents were asked to include such activities as patient care, reading, and teaching. The distribution of responses for each of the four major groups is shown in **Table 2.**

About half (49 percent) of the medical doctors reported working 56 hours or more per week. The mean number of hours for all medical doctors was between 51 and 55 hours—one of eight categories we asked them to use in checking their responses. Data from the doctors of osteopathy indicated that they worked about the same number of hours as medical doctors.

Doctors' doctors and consultants reported working longer hours than either medical doctors or osteopaths. The average for these groups was between 56 and 60 hours per week. Only 13 percent of the doctors' doctors and six percent of the consultants (compared with 35 percent of the medical doctors and 38 percent of the osteopaths) worked 50 hours or less per week, whereas 70 percent of the doctors' doctors and 76 percent of the consultants (compared with 49 percent of the medical

Table 3

33. To what extent does each of the sources listed below offer you stimulation to perform well and to keep up to date in your role as a practicing physician?

		PERCENT responding to a GREAT or VERY GREAT EXTENT:			
		Medical Doctors	Doctors of Osteopathy	Doctors' Doctors	Informal/Formal Consultants
INTERNAL MOTIVATION	(a) My own standards	84	80**	87	87
	(h) My own personal desire to learn and grow	78	77	79	88**
	(b) Unusual medical problems	60	59	65**	74**
OTHER PHYSICIANS	(d) Colleagues with whom I work	50	46**	52	56*
	(f) Interns and residents	32	31	41	39
	(g) Newly graduated physicians	22	23	29**	36**
OTHER PERSONS	(i) My wife (or husband)	21	21	15	18
	(c) Patients becoming more medically sophisticated	18	22*	16	17
	(e) Nursing personnel with whom I work	11	11	8	12
	(j) Administrative personnel in my hospital	6	11**	6	5**
	Average, No Response***	12	11	10	9
	N =	919	183	96	89

---

*The mean of this distribution is significantly different from the mean of the medical doctors' distribution at the .05 level (t-test, 2-tailed).

**The mean is significantly different at the .01 level (t-test, 2-tailed).

***The no response rate averaged for the ten items.

doctors and 47 percent of the osteopaths) worked more than 56 hours or more per week.

Stimulation to Keep Up to Date

The questionnaire contained a number of items about physicians' needs and motivations. One question inquired about sources of stimulation to perform well and keep up to date. Three of the items in this question pointed to internal characteristics as possible sources of stimulation (e.g., "my own standards"). Another three suggested other physicians as sources (e.g., "colleagues with whom I work"). Finally, four items suggested that other persons close to the physician, but not physicians themselves, might provide stimulation (e.g., "my wife [or husband]"). These three types of items were presented in a mixed sequence to the respondents, and they were asked to indicate the extent to which each item offered "stimulation to perform well and to keep up to date in your role as a practicing physician." **Table 3** presents the results.

What is immediately clear from **Table 3** is that internal sources of stimulation are the most important for each group of physicians. Eighty-four percent of the medical doctors, for example, considered "my own standards" as a great or very great source of stimulation. Seventy-eight percent felt that "my own personal desire to learn and grow" was a great or very great source; and 60 percent said that "unusual medical problems" (which presumably elicit an internal response to challenge) were stimulating to the same extent.

Other physicians were a moderate source of stimulation to perform well and keep up to date. Half (50 percent) of the medical doctors said "colleagues with whom I work" were a great or very great source of stimulation. About a third (32 percent) said that interns and residents were stimulating to the same extent, and a little over a fifth (22 percent) felt that newly graduated physicians provided a comparable source of stimulation.

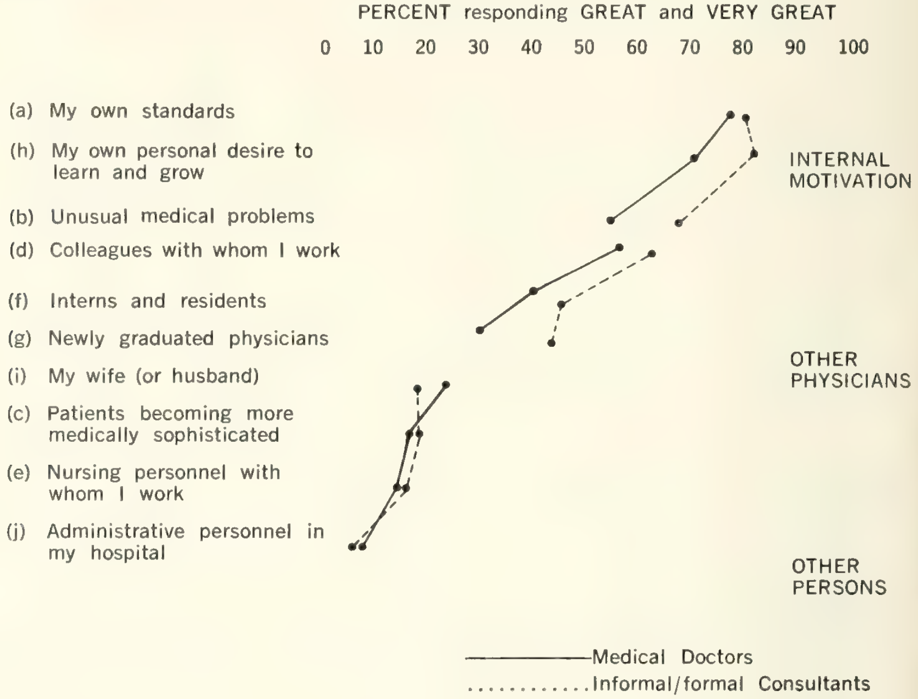
Less important as incentives to quality performance were persons who were not professional peers but who were, nevertheless, close to the physician. Twenty-one percent of the medical doctors said their spouse was a source of great or very great stimulation to perform well and keep up to date, and 18 percent said that medically sophisticated patients were as great a source. Only 11 percent found nurses equally stimulating to keep up to date; and only 6 percent reported that administrators provided a comparable amount of incentive.

Doctors of osteopathy, doctors' doctors, and informal/formal consultants also reported that internal sources of motivation were the strongest. Each group felt that other physicians were less a source of stimulation and that other persons were the least motivating of all.

The most substantial differences among the four groups in their responses to this series of items are shown in **Chart 1. Chart 1** compares the replies of medical doctors and informal/formal consultants, the group which showed the greatest number of

Chart 1

33. To what extent does each of the sources listed below offer you stimulation to perform well and to keep up to date in your role as a practicing physician?



significant differences (five) from medical doctors. As can be seen, consultants were distinguished from medical doctors in reporting that both internal motivation and stimulation from physician colleagues were greater. In particular, consultants reported "my own personal desire to learn and grow," "unusual medical problems," "colleagues with whom I work," and "newly graduated physicians" as significantly greater sources of stimulation to perform well and keep up to date, and they indicated "administrative personnel in my hospital" to be significantly less important as a source of stimulation. While doctors' doctors showed fewer significant differences from medical doctors, they were like the consultants in reporting greater stimulation from internal sources and from physician colleagues (see **Table 3**).

Where osteopaths differed from the general sample of medical doctors on these items, it was in a direction opposite to that of the criterion physicians. Thus, significantly fewer osteopaths than medical doctors indicated that "my own standards" and "colleagues with whom I work" were great or very great sources of stimulation, and significantly more reported that "patients becoming more medically sophisticated" and "administrative personnel in my hospital" were comparable sources of stimulation (see **Table 3**).

To summarize, for each of the four groups of Michigan physicians it was found that internal motivation was a greater source of stimulation to perform well and keep up to date than were other physicians. Other physicians, in turn, provided more incentive than persons close to the physician who were not physicians themselves. The criterion doctors reported even greater stimulation than medical doctors from internal sources and from their colleagues—especially the newly graduated physicians—whereas osteopaths reported slightly less motivation from these sources and significantly more from patients and hospital administrators.

Overall Evaluation of Continuing Education

All physicians in our survey were asked for an overall evaluation of the quality of continuing education available to them in their own hospitals and in the state of Michigan at large. Two questions were designed to obtain these evaluations. They were placed at the end of the questionnaire to allow the physicians to think back over all of the questions they had been asked and to make their own summary evaluation of all the continuing education activities available to them (1) in the hospital with which they had their major affiliation and (2) at the statewide level within Michigan. The responses to these questions are particularly important for they provide the only overall evaluation we obtained of how the physicians rated the continuing educational opportunities in their immediate potential learning environment.

Table 4

38. How would you rate the overall quality of continuing education available to you in the hospital with which you have your major affiliation? (Including formal programs, informal consultations, discussions, meetings, conferences, etc.)

	Medical Doctors		Doctors of Osteopathy		Doctors' Doctors		Informal/Formal Consultants	
PERCENT responding:								
(5) Outstanding	6	26	4	15	4	26	4	20
(4) Excellent	20		11		22		16	
(3) Good	29		26		21		25	
(2) Fair	21	35	27	49	29	45	28	48
(1) Poor	14		22		16		20	
No Response	10		10		8		7	
	100		100		100		100	
N =	919		183		96		89	
Mean =	2.81		2.40**		2.67*		2.53**	
Std. Dev. =	1.13		1.10		1.15		1.15	

---

*The mean of this distribution is significantly different from the mean of the medical doctors' distribution at the .05 level (t-test, 2-tailed).

**The mean is significantly different at the .01 level (t-test, 2-tailed).

The hospital is generally recognized as an important site for much of the physician's learning. It is here that he often consults informally with other physicians, obtains their formal advice of how to manage particularly difficult problems outside of his own competence, and attends a number of monthly meetings with other members of the medical and hospital staff. How did he rate the overall quality of continuing education available to him in this setting?

A quarter (26 percent) of the medical doctors in the state rated the quality of in-hospital continuing education as outstanding or excellent; 29 percent evaluated it as good, but more than a third (35 percent) considered it only fair or poor (**Table 4**). Doctors of osteopathy were significantly less satisfied than medical doctors with the overall quality of education available to them in their hospitals. Only 15 percent of them rated in-hospital educational opportunities as outstanding or excellent, while more than three times this figure (49 percent) thought of the quality of education as fair or poor.

The two criterion groups of physicians—doctors' doctors and informal/formal consultants—were also significantly more critical than medical doctors of the quality of continuing education available in their hospitals. Twenty-six and 20 percent, respectively, felt the education was outstanding or excellent, but nearly twice as many (45 and 48 percent respectively) considered it only fair or poor.

Physicians were also asked to summarize their feelings about the quality of continuing education available to them on the statewide level in Michigan. Here they were invited to give an overall rating to the programs of the medical schools, the medical society, and other groups operating at this level. **Table 5** displays the results for the four major groups of respondents.

Thirty-eight percent of the medical doctors in Michigan evaluated the education available on the statewide level as outstanding or excellent; 34 considered it good; and only 18 percent thought of it as fair or poor. Doctors of osteopathy were significantly more pleased with statewide continuing education, 43 percent of them evaluated it as outstanding or excellent, 37 percent as good, and only 11 percent as fair or poor.

The criterion physicians were significantly less positive than medical doctors about the quality of continuing education available in the state. Only 25 percent of the doctors' doctors and 31 percent of the consultants evaluated the educational opportunities as outstanding or excellent; 36 and 37 percent of each group considered them good; but as many as 30 percent of the doctors' doctors and 25 percent of the consultants thought of them as only fair or poor.

Chart 2 summarizes the responses of the four groups of physicians to these two questions. As can be seen, all four groups were more positive about the education available to them on the statewide level (considered "good" to "excellent") than they were about the education available to them in their own hospitals (considered "fair" to "good"). The discrepancy between these two sources of education was most notable for osteopaths: they were the least positive of the four groups about in-hospital education but most positive about in-state education. Doctors' doctors and

Table 5

39. How would you rate the overall quality of continuing education available to you on the statewide level in Michigan? (Including medical school programs, state medical society programs, etc.)

	Medical Doctors		Doctors of Osteopathy		Doctors' Doctors		Informal/Formal Consultants	
PERCENT responding:								
(5) Outstanding	6	38	15	43	3	25	4	31
(4) Excellent	32		28		22		27	
(3) Good	34		37		36		37	
(2) Fair	15	18	10	11	27	30	23	25
(1) Poor	3		1		3		2	
No Response	10		9		9		7	
	100		100		100		100	
N =	919		183		96		89	
Mean =	3.24		3.51**		2.94**		3.10**	
Std. Dev. =	0.94		0.94		0.90		0.91	

**The mean of this distribution is significantly different from the mean of the medical doctors' distribution at the .01 level (t-test, 2-tailed).

Chart 2

Comparison of In-Hospital and In-State Evaluations of Continuing Education

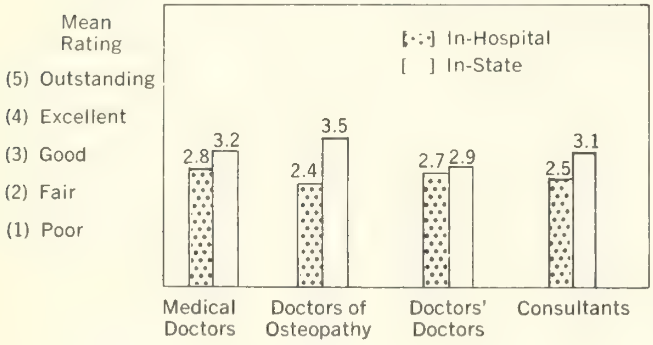
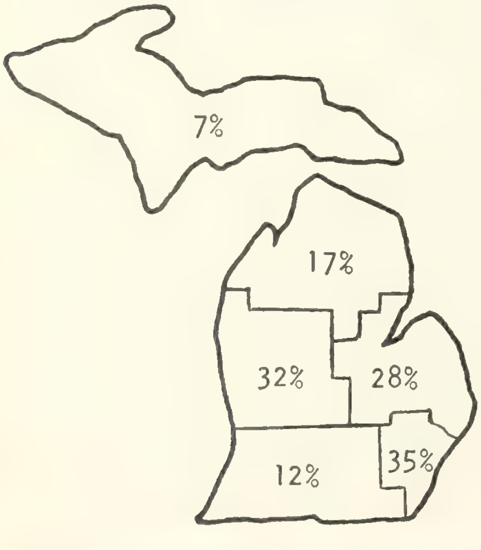


Chart 3

Overall Evaluation of In-Hospital Education by Region for Medical Doctors



consultants, physicians whom our evidence suggests were more competent, were less positive than medical doctors at large both about in-hospital and about in-state continuing education.

After comparisons were made of the four major groups of respondents, the general sample of medical doctors was analyzed to see if any differences in evaluations of continuing education were associated with location in Michigan, specialty, type of practice, age, or size of the hospital of major affiliation. The analysis was performed both for evaluations of in-hospital education and evaluations of education at the statewide level. The significant associations that were found are presented below.

Region: Chart 3 shows that medical doctors in the southeastern part of Michigan rated the quality of continuing education available in their hospital more positively than doctors in several other regions. Thirty-five percent of those who checked one of the five alternative evaluative answers to this question[4] felt that the education available in their own hospital was outstanding or excellent. The MD's in the southeastern area were more satisfied than the MD's in the southwest, north central, and upper peninsula areas; they were not, however, significantly more favorable in their evaluations of the continuing education available in their hospitals than those physicians in the west central region which included Grand Rapids. Medical doctors in the upper peninsula were least positive about the educational opportunities in their hospitals; only 7 percent of them considered them outstanding or excellent. Medical doctors showed no differences by region in their evaluation of continuing education available at the statewide level.

---

[4] The percentages used in this chart—and in the remaining tables in this article—are on a different base than those given in the preceding table; the MDs not responding to the question (10 percent) were dropped at this stage of the analysis so that programmed tests of significance could be used. The differences among regions are what should be noted here. For example, five times as many MDs in southeastern Michigan as compared to the upper peninsula are satisfied with their own hospital's C/E.

Hospital Size: Medical doctors in the larger hospitals were clearly much more satisfied with the quality of continuing education available to them *in their hospitals* than doctors in the hospitals having fewer beds (**Chart 4**). Over half (53 percent of those who gave evaluative answers) of the doctors affiliated with hospitals of 600-699 beds rated continuing education in their institution as outstanding or excellent, and only 21 percent (not shown in Chart 4) said it was only fair or poor. In the smallest hospitals, those with 99 or fewer beds, these two proportions were 9 ("outstanding-excellent") and 67 ("fair-poor") percent, respectively. **Chart 4** shows the straight forward relationship between quality of continuing education in their hospital reported by medical doctors and the size of hospital of major affiliation.

These findings relating hospital size to evaluations of own-hospital continuing education were predictable from the association between region and evaluations of hospital education. The largest hospitals in Michigan are in the southeast (where evaluations are more positive) and the smallest ones are in the upper peninsula (where evaluations are least positive). As before, there was no significant association between hospital size and evaluations of continuing education at the statewide level.

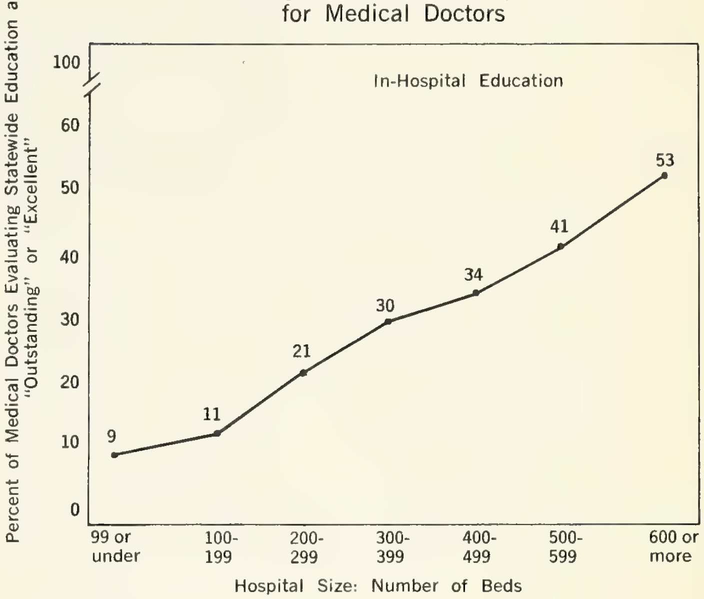
Specialty: General practitioners were the most positive of Michigan doctors about the quality of education available to them *at the statewide level* (**Chart 5**). Fifty-seven percent of those who responded to this question considered the education outstanding or excellent, more than twice the percentage of pediatricians (26 percent) who found it of equal quality. There was no comparable association between specialty and evaluations of in-hospital education.

Medical doctors who are general practitioners thus paralleled doctors of osteopathy (most of whom are general practitioners) in their evaluations of statewide continuing education. Osteopaths were the most positive of the four major groups of Michigan physicians in their ratings of education in the state at large (see **Table 4**).

Age: Medical doctors in Michigan were distinguished by age not only in their evaluations of *in-hospital* education but also in their ratings of *statewide* education. **Chart 6** presents the evaluations of both sources made by doctors of differing ages.

Chart 4

Overall Evaluation of In-Hospital Continuing Education by Hospital Size for Medical Doctors



In evaluating educational opportunities *in their own hospital*, the youngest (35 and under) and oldest (over 65) doctors were the most enthusiastic. Thirty-eight percent of the former group and 40 percent of the latter rated the education available as outstanding or excellent, while only 24 to 29 percent of those in the 36-65 brackets did.

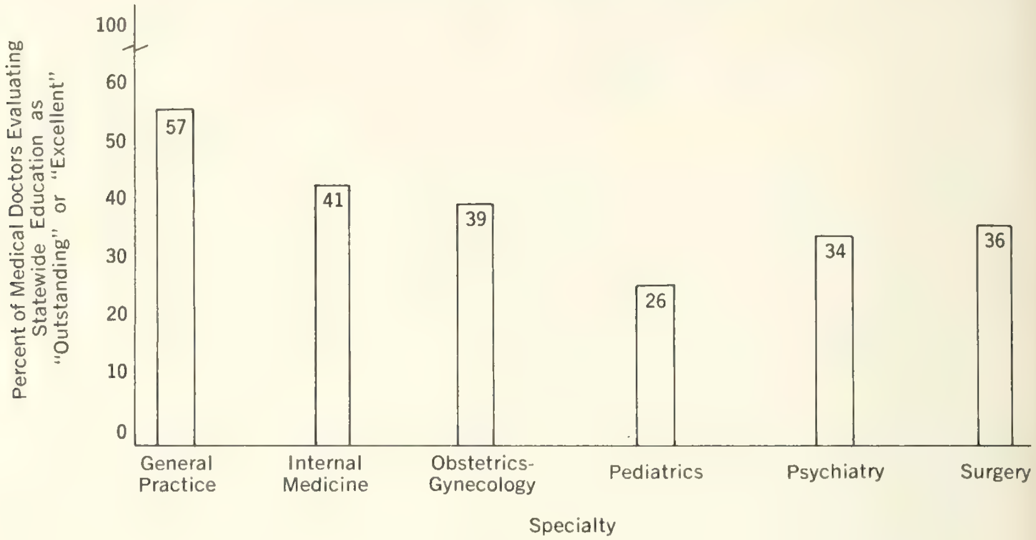
In rating *statewide* continuing education, the older physicians were the most positive. Fifty percent of those in the 56-65 bracket and fully 58 percent of those over 65 thought of education available at this level as outstanding or excellent, compared with only 33 to 39 percent of those in each of the brackets under 56. Since more older physicians were in general practice, this finding was predictable from our knowledge that general practitioners were more positive than specialists about statewide education.

When we compared evaluations of these continuing education opportunities at the hospital and at the state level, we discovered that the tendency to think of statewide education as superior to in-hospital education did not appear until a doctor reaches 36 and then the tendency became more pronounced with increasing age.

To summarize our findings regarding overall evaluations of continuing education at the hospital and at the state level:

Chart 5

Overall Evaluation of Statewide Continuing Education by Specialty for Medical Doctors



—Medical doctors in Michigan thought of education available in the hospital as fair to good and that available in the state as good to excellent.

—Doctors of osteopathy were less positive than medical doctors about education available in the hospital and more positive about education available in the state.

—Doctors' doctors and consultants were less positive than medical doctors both about education available in the hospital and about education available in the state.

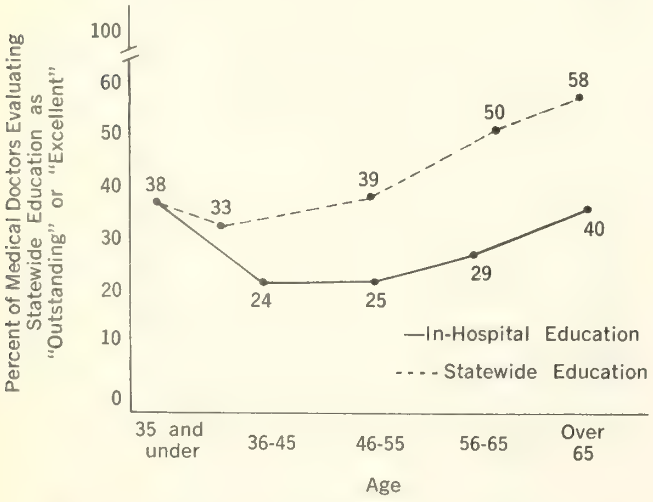
—Among medical doctors:

—Those in southeast Michigan, those at larger hospitals, and those in the youngest and oldest age brackets were most positive about in-hospital education.

—General practitioners and those over 55 were most positive about education at the statewide level.

Chart 6

Overall Evaluation of In-Hospital and Statewide Continuing Education by Age for Medical Doctors



A Summary and a Preview

These few findings delineate rather well the nature of the continuing education problem. The typical Michigan physician is strongly motivated by his own standards and by the presence of physician colleagues to keep abreast of new developments in medicine. Yet he works a long week in which he can devote only 2 to 3 hours to the medium of education he deems his best. The education available to him in his hospital he considers in the fair-to-good range and that available in the state at large in the good-to-excellent range, although the doctors most respected by their peers are less positive about either source of education. The problem facing continuing education planners, then, is to devise programs that capitalize upon motivational forces within the physician and at the same time show an awareness of the constraints under which he labors.

Subsequent articles in this series have as their goal the facilitation of the planning task. We will explore in greater detail the motivation the physician has to keep up to date, the forces that prevent him from doing so, the educational activities he engages in, the evaluation he makes of these activities, and, finally, the innovations he would like to see in the future.

Non-invasive Approaches To Cardiac, Vascular, And Pulmonary Dynamics

By Jan Nyboer, D.Sc., M.D.
Detroit

Introduction

The non-traumatic approaches to cardiovascular studies with the exception of electrocardiography have been grossly neglected in view of the apparent quantitative successes of the sanguinous approaches. These latter methods were spearheaded by human cardiac catheterization techniques in the last three decades. The more humane demands for equivalent dynamic information on organ functions by the accelerating space programs have now flowed over to the clinical programs in acute coronary and intensive care situations. Under these conditions it is equally rational to monitor cardiorenal, cardiopulmonary, and cardiovascular functions by non-invasive techniques. In my opinion, a list of the applicable non-invasive principles may involve: (1) sounds,[5,7] (2) vibrational effects,[1] (3) Doppler effects,[12] (4) thermal deviations, (5) visual and photographic effects, (6) gravity,[3] (7) optical effects, (8) magnetic changes, (9) electrical fields, (10) low pressure effects[2] (11) displacement devices,[2,14] (12) isotope dilutions under some conditions, (13) ballistic effects,[3,15] (14) X-ray fluorodensity,[10] and (15) conductivity changes — resistive[14] and capacitative.[13] As my own interests have centered largely on electrical impedance of tissue and on various ballistic devices, the quantifying systems of conductance and force will be emphasized in this present theme as measures of organ functions. I am indebted to Dr. Franklin Johnston for much encouragement in this time-consuming development of concepts and instruments for more than three decades.

I have often said in the past that the catheter should have at least six or more senses with respect to time. In non-evasive techniques one should correct this concept, because it is the detector that needs such sensing ability. In reality, the nature of the detector is irrelevant. However, the motion, displacement, or space of the circulation *or* body water *or* lung space must be transformed to a voltage signal. This signal can be recorded, stored, or digitized for instrumental intelligence and computerized analysis.

Doctor Nyboer is director of research, Department of Physical Medicine, Rehabilitation Institute; professor of physiology and pharmacology, Wayne State University College of Medicine, and Associate in Medicine and Cardiology, Harper Hospital, Detroit.

Sounds and Vibrations

Precordial sounds and vibration frequencies are dependent on the underlying cardiac dynamics of each beat. Foulger hypothesized that the "mean" harmonic of the intensity-frequency distribution over systolic intervals is related in a simple manner to the rate of change in length of the ventricular fibers and, therefore, to the rate of change of the ventricular volume.[5] By integrating all chest wall harmonics a curve is produced similar to the ventricular volume. See Fig. 1. This is verified by the pattern of the progressive positions of the "heart sound meter." The formula for stroke volume in milliliters which he derived equals a constant K_1 for the recorder times the difference in the square of the frequencies (f^2_1 max. - f^2_2 min.). A coefficient of correlation of .95 ± .02 was obtained in comparison with high frequency Starr ballistocardiograph formulas. The method was abandoned in 1953 because of electronic difficulties in reproducing equipment, but Foulger believes modern engineering systems can overcome past handicaps. He was greatly encouraged by Drs. Johnston and Overy's studies in precordial vibration with strain gauges.[7]

Agress and his co-workers have continued their extensive vibratory studies of the chest and devised an instrument that also defines stroke volumes for NASA commitments.[1]

Peripheral arterial Korotkoff sounds or bruits beyond or under a constricting blood pressure cuff are used to define peripheral systolic and diastolic levels intermittently.[14] The form and amplitude of the primary and reflecting pressure-volume waves in the limb beyond the cuff have a similar function to sound as shown by studies of Erlanger and co-workers before the turn of the century.[4] The diastolic event has been detected by the appearance of dicrotic notches with decrescendo pressures, when the pulse is sensed oscillometrically *beyond* the occlusion cuff by modern electronic devices including impedance. See Fig. 2. On the other hand, Kneppo has shown that with crescendo pressure application the impedance pulse volume contour is altered beneath the cuff.[9] There is a flattening of the diastolic-systolic angle on reaching the diastolic pressure level. See Fig. 3.

---

*Read at the Franklin D. Johnston Cardiology Symposium, University of Michigan Medical Center, Ann Arbor, June 26 and 27, 1969.

Doppler Effects

Central and peripheral blood flow, vessel and heart movements as followed by ultransonic wave transmissions and reflections, are also reaching into complex circulatory problems without skin injury. As a final tool for following blood flow quantitatively, it is still deficient. However, it is sensitive to venous, arterial and some capillary events. Dr. Light of London feels that the geometry of the aortic arch is favorable for quantitative work, because no correction for angle is required, if the incidence of the ultrasonic beam is tangential.[12] The contour of the systolic wave gives valuable clues on the pumping performance of the heart. He also believes that the stroke volume is proportional to the integral of velocity over each systolic period. It is a safe method but needs improvement for research and clinical use.

Thermal Effects

The ability of thermistor scanning to detect relative differences in body surfaces from infrared radiation has become a valuable diagnostic adjunct in numerous clinics. One is able to define hot spots associated with malignant growths and also qualitative regional differences in occlusive diseases affecting the extremities. In a quantitative sense calorimetry represents a metabolic function closely related to integrated circulatory activity.

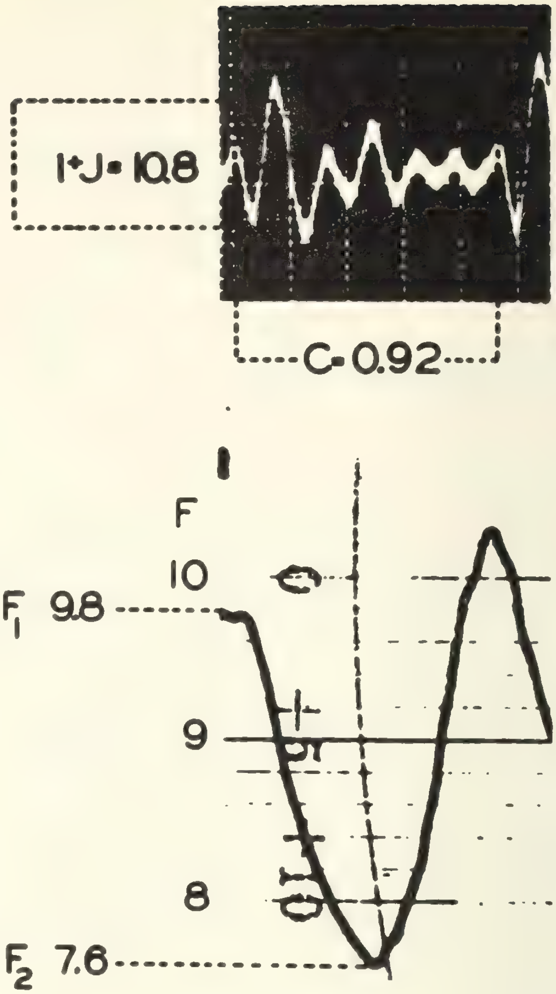


Fig. 1—The integral of precordial vibrations resembles ventricular volume changes. Permission of Foulger, Amer. H. J. 35, 1948.

Ballistic Effects

Among the remaining approaches listed ballistocardiography, however sophisticated and inadequately developed, is an excellent non-invasive ap-

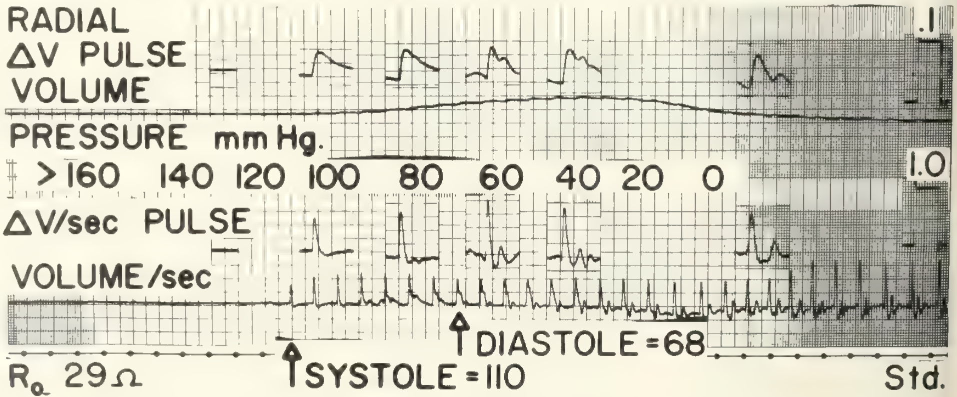


Fig. 2—The contour and amplitude of volume pulses in the forearm varies with the level of occlusion pressure in the brachial cuff. Permission of Nyboer, **Electrical Impedance Plethysmography,** second edition. 1970 C. Thomas Publications.

proach to cardiovascular and respiratory dynamics. The spatial concepts of body dynamics with each heart beat is already recorded by accelerometry in simultaneous orthogonal planes.[3] Such studies at zero gravity are realized from trajectory plane flights and probably space experiments. The basic mathematics and definition of maximum motion and force produced by a rotating eccentric mass reassures us of a linear standard of motion and force for such biomechanic relations. These are summarized as: Fig. 4A.

These equations assist us in calibrating pendular, spring or aperiodic air supported bed systems with natural restoration or counterforce equilibriums.[15] See Fig. 4b. The spectrum of BCG differences between infants and adults are definable as shown and measured by open and closed loop integrating or differentiating systems. See Figs. 5 & 6.

The difficulty in BCG curve analysis is multiplied and often confused by disease, particularly coronary, but this can be simplified by adjunct absolute forms of velocity and force events in force and counterforce systems. For such rearranged complexes, the integrations describe variations which are an aid to the assessment of therapy or cardiac status. BCG's as quantitative indices of cardiac output will have a definite role in the future. The following study of exercise illustrates this.[15] See Fig. 7. Note that the flow index and absolute force index show an equivocal change. The major criticism of all BCG's is the superimposed resonance factor at play, particularly in the rigid table. A clear demonstration of its abolition is shown by recording the subject before and after surrounding the subject with styrofoam balls. See Fig. 8. The resultant simulated displacement from a counterforce source resembles displacement records from the ultra low frequency pendulum. I believe that most of these criticisms of BCG can be coped with in the definition of stroke work, since the changes in flow and work indices are essentially the same under conditions of stress.

Electrical Impedance Plethysmography[2,14]

In the final analysis ballistocardiography and total body plethysmography should yield identical information about the flow and energy associated with each heart beat. Each is dependent on cardiac systole, diastole, and arterio-venous mass movement or volume differences.

Numerous researches on circulation were reported a few weeks ago at the Symposium on Impedance Cardiography held at the NASA Manned Spacecraft Center. Many of these studies supported Kubicek's contention that the maximum impedance slope of the chest pulse in dogs and man is an adequate measure and is related to stroke volume.[11] This analytic method is similar to Zajic et al of Czechoslovakia.[18] These deductions were based on parallel electrical law and certain physical relations of tetrapolar leads used in the study. A high or adequate coefficient of correlation of flow was obtained with dye dilution, Fick principle, electromagnetic flowmeter, beat-by-beat pressure pulse comparison, and isotope dilution methods. The impedance methods were applied clinically in studies of human cardiac transplants, cardiomegaly, acute dissecting aneurysm, myocardial contractility, other cardiac disorders, detection of pulmonary edema as well as during the use of pharmacologic agents. At the Air Force Academy of Colorado Springs, Gowen and his associates measured and immediately calculated human cardiac output from impedance pulses in experiments (by Kubicek's equation) each minute. Stress was produced by body tilt and lower body negative pressure. These impedance results appear similar to the effects of positive pressure breathing as reported by us elsewhere.[8]

In a few clinical observations of heart disease we made Fick or dye dilution studies. These showed a close relation to cardiac indices of flow based on torso impedance plethysmography.[14] See Fig. 9a. A comparison of the formulas used in the above independent observations for minute volume by Kubicek[11] and ourselves are of interest. They are both dependent on parallel electrical resistance but vary in the length of the electrical path, the base resistive impedance, and the manner of extrapolating for the effective pulse impedance. Kubicek's formula is dependent on the forward slope, and ours is dependent on the early and

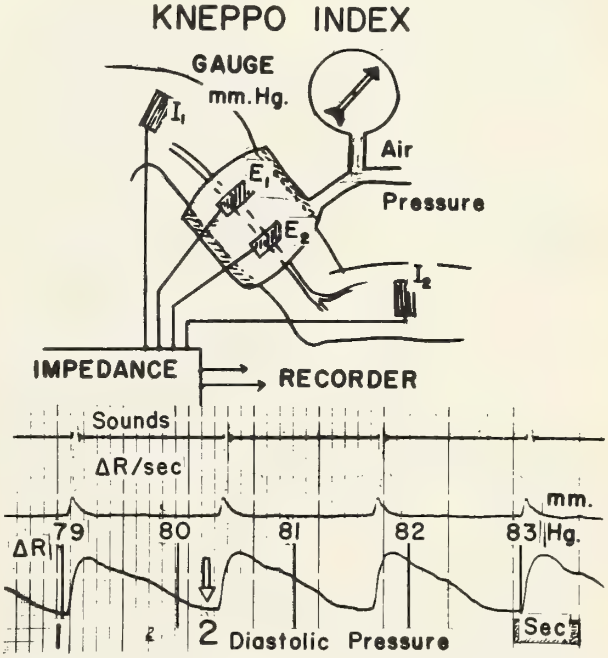
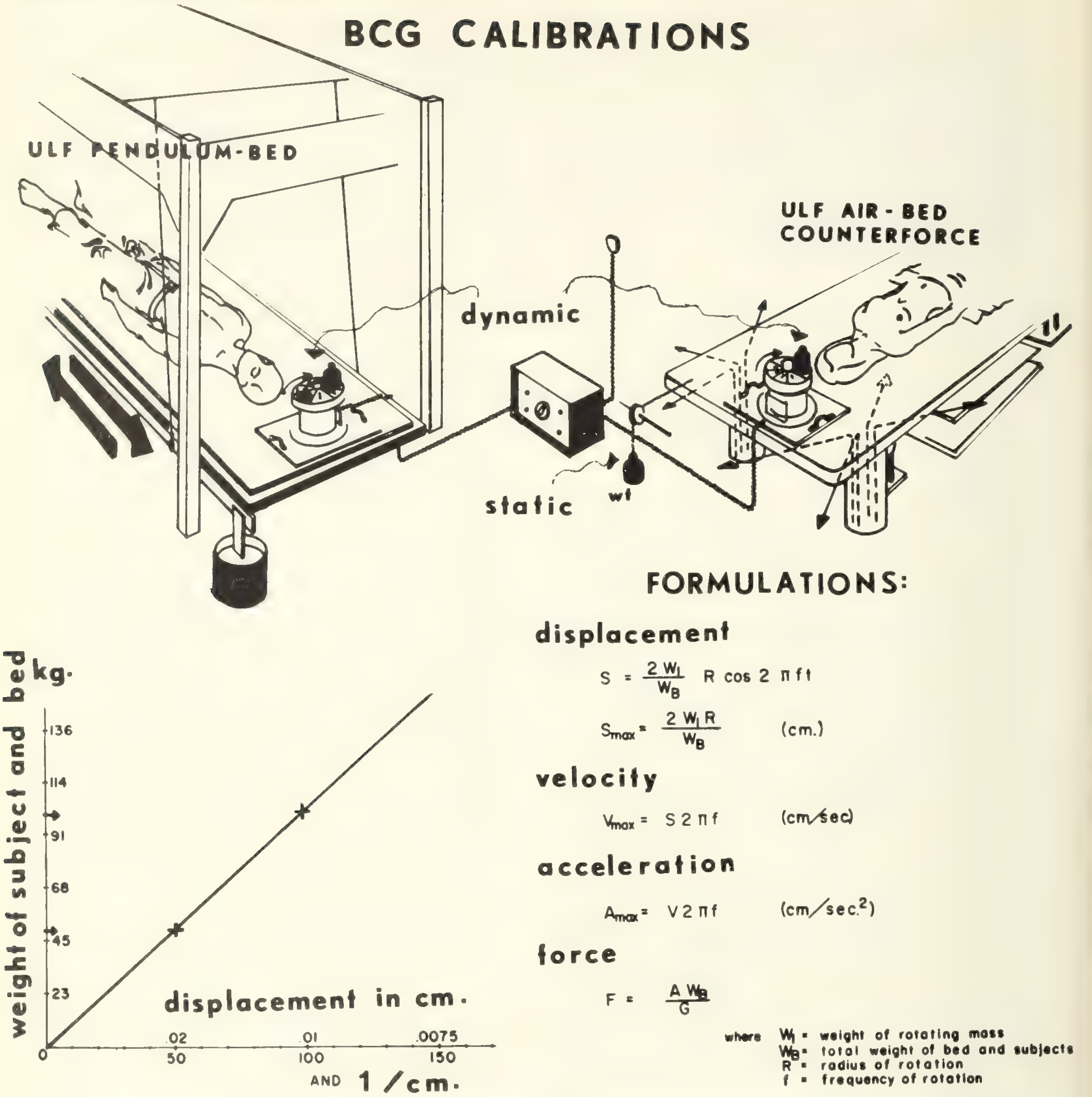


Fig. 3—The diastolic pressure is detectable by the change in form at diastolic-systolic junction.


BCG CALIBRATIONS
ULF PENDULUM-BED
ULF AIR-BED
COUNTERFORCE
dynamic
static
wt
weight of subject and bed
kg.
136
114
91
68
45
23
0
displacement in cm.
.02
.01
.0075
50
100
150
AND 1 /cm.
FORMULATIONS:

displacement

$$S = \frac{2\,W_1}{W_B}\,R\cos 2\pi f t$$

$$S_{max} = \frac{2\,W_1 R}{W_B} \qquad \text{(cm.)}$$

velocity

$$V_{max} = S\,2\pi f \qquad \text{(cm/sec)}$$

acceleration

$$A_{max} = V\,2\pi f \qquad \text{(cm/sec}^2\text{)}$$

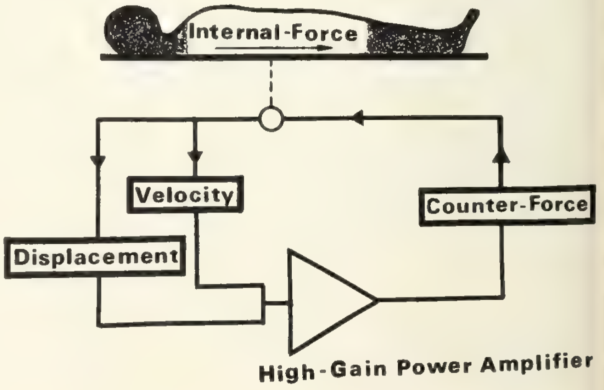
force

$$F = \frac{A\,W_B}{G}$$

where W_1 = weight of rotating mass
W_B = total weight of bed and subjects
R = radius of rotation
f = frequency of rotation

Fig. 4a.—Dynamic, static, mathematical and graphic concepts of ballistic calibrations for Mass Movements.

Fig. 4b.—Principle of Counterforce BCG recordable with a flat frequency response from 0-20 Hertz.


Internal-Force
Velocity
Counter-Force
Displacement
High-Gain Power Amplifier

systolic slope. At present, the Minnesota Impedance Cardiograph still has an inadequate range of measurement for many limb impedance problems. This includes those measures related to total body water suggested by Dr. Hoffer of Alabama[6] and Dr. Thomassett of Marseilles, France.[16] The details of our own system of impedance measurement is in press.[14]

The general appearance of a torso plethysmogram is similar to the total chest plethysmogram and can be measured simultaneously with slaved impedance circuits. See Fig. 9b. Fig. 10 shows torso pulse records before and after conversion of irregularities secondary to atrial fibrillation and clinical decompensation. The patient was relieved of complaints, and the torso flow index was improved from 3.4 and 3.72 liters/minute in one day.

If the chest is studied by impedance transversely, the respiratory and pulmonary vascular functions are recordable as right and left functions. See Fig. 11. The correlation with similar functions evaluated by fluorodensigraphy of Kourilsky, Marchal, and Marchal is uniquely similar.[10] See Fig. 11a & 11b. This is shown in the normal and abnormal studies. See Fig. 12, 13, 14. A tabular experience of 10 subjects was made by a medical student, Miss Lynne Williams, and the author.[17] See Fig. 15. This defined the percentile differences in vital capacity, the timed vital capacity, and the posterior chest pulsations calibrated in terms of air and blood displacements.

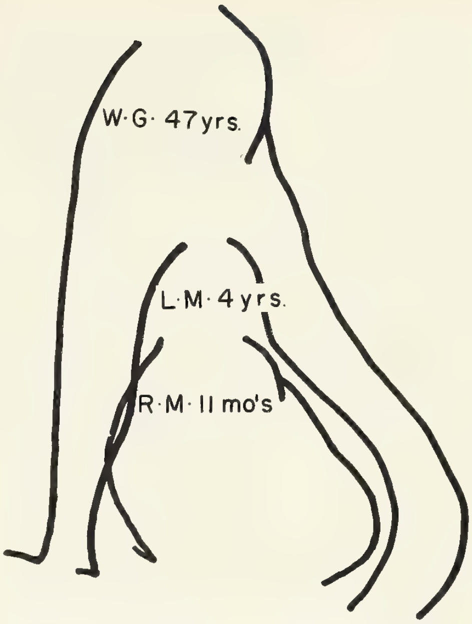


Fig. 5—Outlines of relative sizes of hearts from 1, 4 and 47 years.

The application of impedance to peripheral measurements appears reliable under most circumstances. In the illustrated case of Leriche syndrome there is a moderate increase in pulsatile dynamics following the insertion of a by-pass graft. See Fig. 16. The availability of the tested tetrapolar impedance instruments is still poor, while the uses for impedance measures are increas-

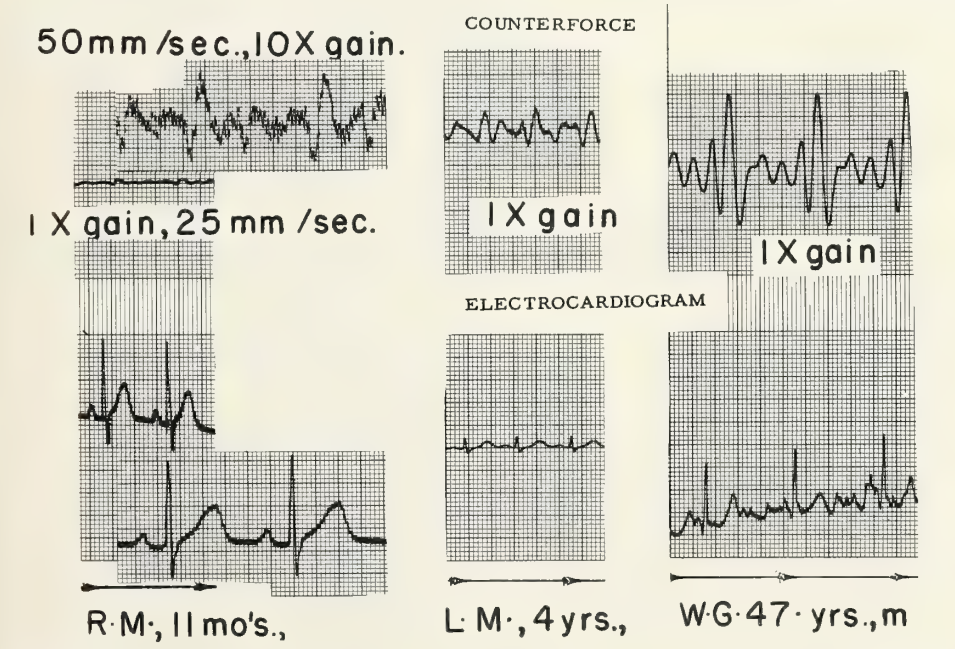

50mm/sec., 10X gain.
1 X gain, 25 mm/sec.
COUNTERFORCE
1X gain
1X gain
ELECTROCARDIOGRAM
R·M·, 11 mo's., f, 18 lbs., normal heart.
L·M·, 4 yrs., m, 38 lbs., normal.
W·G· 47· yrs., m 185 lbs., normal

Fig. 6—Relative counterforce ballistics in above cases also vary greatly and are quantitatively different. Smallest force associated with smallest heart and subject in correct proportion to larger hearts.

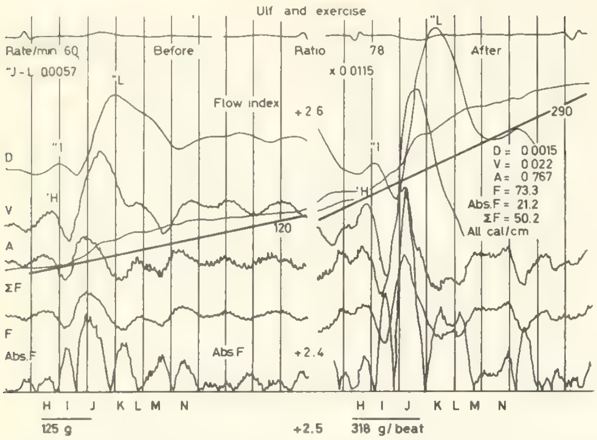


Fig. 7—Exercise effects a great change in pendulum ULF displacement, velocity, acceleration, and force. Note absolute forms easily identify relative heights of HIJ (Abs. F), etc. Their areas are easily summated (F) for slope studies.

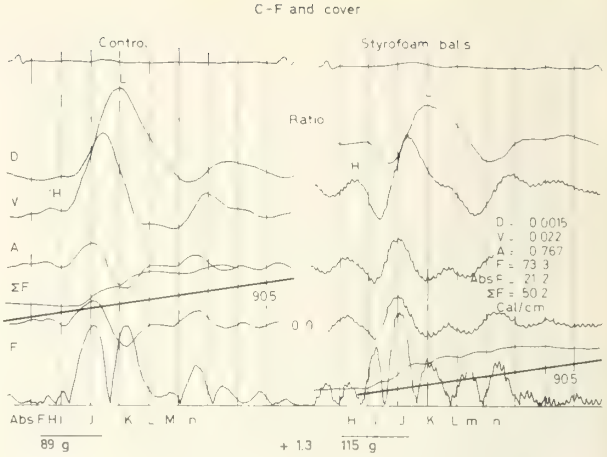


Fig. 8—Counterforce BCG's have a large resonant content. This is abolished by covering the subject with styrofoam balls which damp these unwanted oscillations. The new curve simulates the ULF displacement curve.

ing. We believe that tetrapolar impedance is an adequate approach to non-invasive dynamics of a physiological and pathological nature. See Fig. 17 for various pulse forms.

Summary and Discussion

The role of non-invasive techniques is of increasing importance to experimental and clinical circulatory and respiratory problems. Each principle must be clearly understood to differentiate artifacts from real function. It is feasible to quantitatively evaluate cardiac function from changing harmonic frequencies of the precordium, cardioballistics, tetrapolar total torso and upper torso electrical conductance. Respiratory as well as pulmonary vascular pulsations may be evaluated by electrical conductance,[14] capacitance,[13] and roentgen fluorodensigraphy[10] without trauma unilaterally, bilaterally and totally. Displacement, velocity, acceleration and force characteristics are often recorded and analyzed simultaneously. The absolute forms of velocity and acceleration events

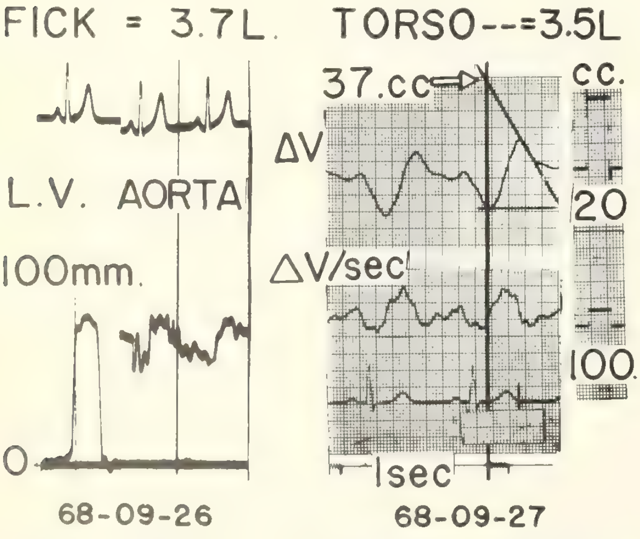


Fig. 9a—Note the Fick and torso plethysmographic estimation of cardiac output indices are equivocal.

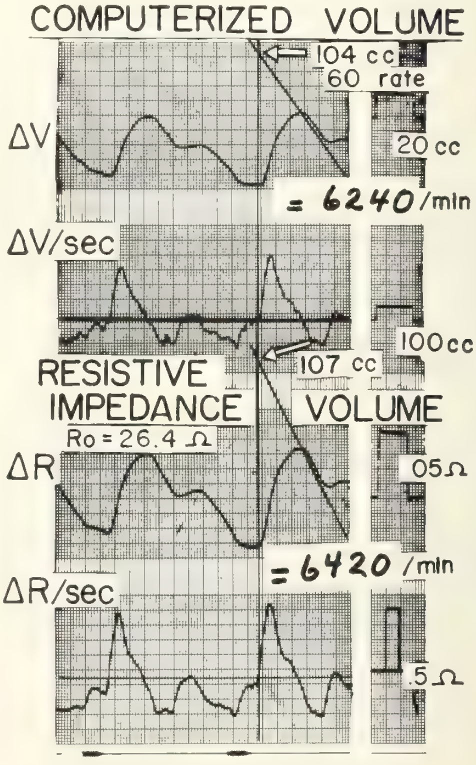


Fig. 9b—Human torso pulses may be analyzed for total cardiac dynamics from displacement and first derivative impedance plethysmograms.

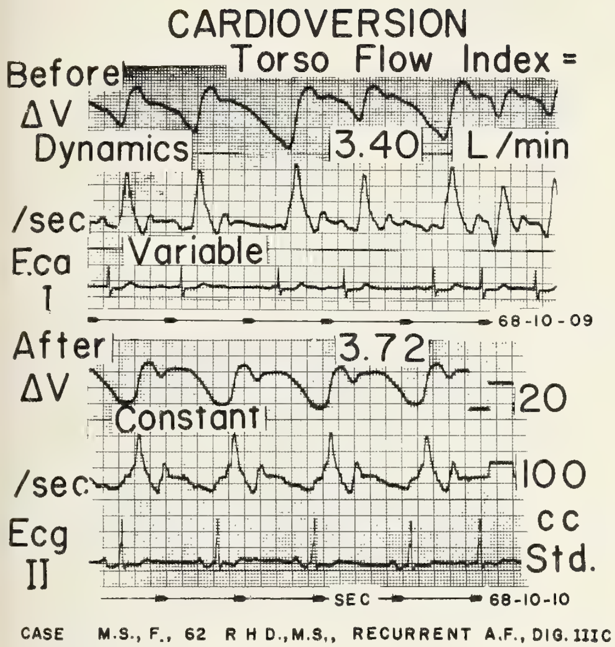


Fig. 10—Cardioversion shows slight increase in torso flow index after one day. Patient improved.

are an aid to summing their areas and judging relative acceleration and deceleration phenomena with each heart beat.

Acknowledgements

Grants-in-aid for these studies were provided by the Michigan Heart Association and the Michigan Kenny Foundation. Technical assistance of Charles Stilson, Kenneth Reid, David Horowitz, and Dr. Walter Gessert were appreciated.

Bibliography

1. Agress, C. M., Wegner, S., Fremont, R. P., et al: Measurement of Stroke Volume by the Vibrocardiogram. *Aerospace Med. 38:* 1248-1252, 1967.
2. Allison, R. D.: The Potential Role of Impedance Plethysmography in Aerospace Medicine. First Symposium on Impedance Cardiography, NASA Manned Spacecraft Center, Houston, Texas, 1969.
3. Beischer, D. E. and Hixson, W. C. (Pensacola, Florida): Triaxial Ballistocardiogram in a Weightless Environment. Scientific Meeting of Ballistics, April 12-14, 1965, Amsterdam, Netherlands.
4. Erlanger, J.: Studies in Blood Pressure Estimation by Indirect Methods. II. The Mechanism of The

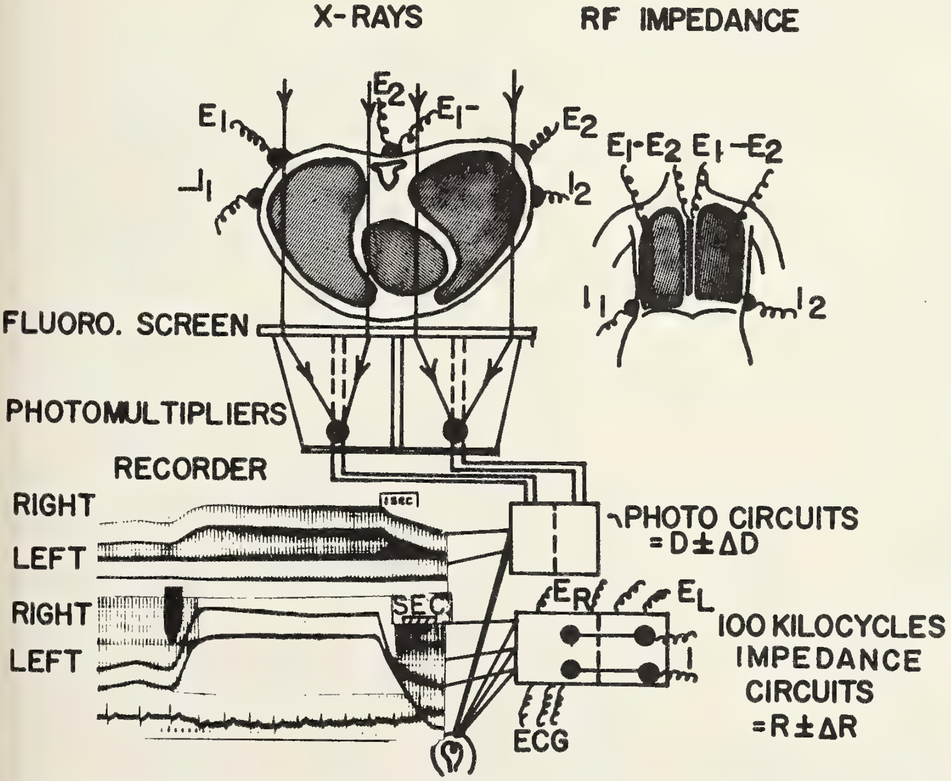
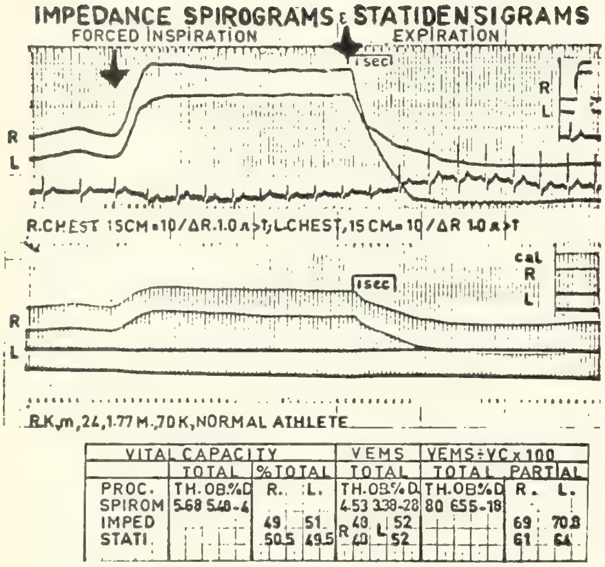

X-RAYS
RF IMPEDANCE
E1
E2
E1-
E2
E1-E2
E1-E2
I1
I2
I1
I2
FLUORO. SCREEN
PHOTOMULTIPLIERS
RECORDER
RIGHT
LEFT
RIGHT
LEFT
1sec
SEC
PHOTO CIRCUITS
=D±ΔD
ER
EL
100 KILOCYCLES
IMPEDANCE
CIRCUITS
=R±ΔR
ECG

Fig. 11—Diagram of simultaneous method of bilateral chest impedance and roentgen density study.



	VITAL CAPACITY			VEMS	VEMS÷VC x 100		
	TOTAL	%TOTAL		TOTAL	TOTAL	PARTIAL	
PROC.	TH. OB. %D	R.	L.	TH. OB. %D	TH. OB. %D	R.	L.
SPIROM	5.68 5.40 -4			4.53 3.38 -28	80 65.5 -18		
IMPED		49	51	R 40 L 52		69	70.8
STATI		50.5	49.5	40 52		61	64

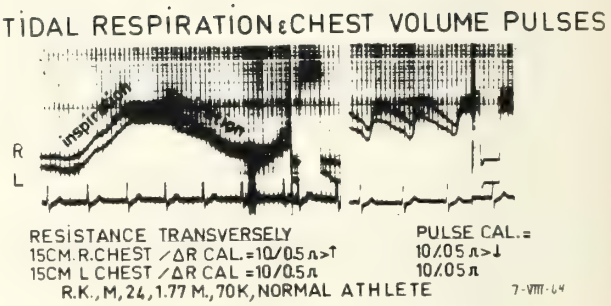


Fig. 11a & b—Respiratory and pulse volume data are recorded independently by impedance plethysmography of the right and left chest posteriorly and by roentgendensitometry (statidensigram) of Drs. Marchal and Marchal.

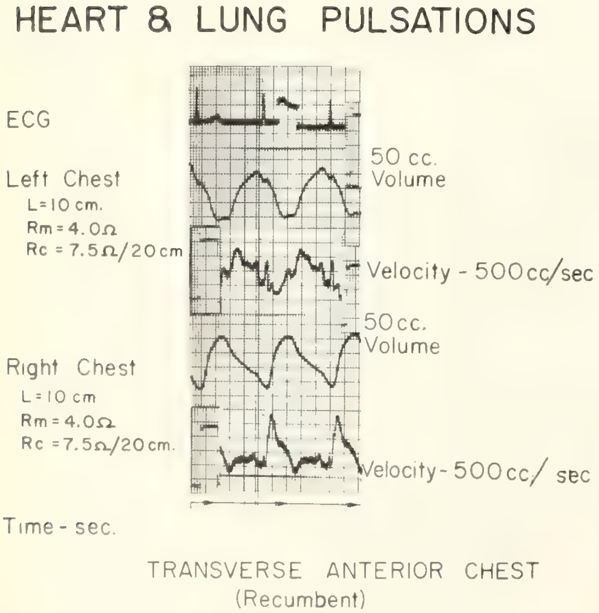


Fig. 12—Smaller segments of right and left anterior chest show real differences. One is a cardiogram, the other is a pulmonary plethysmogram.

Compression Sounds of Korotkoff. *Amer. J. Physiol. 39:* 82-125, 1915-1916.

5. Foulger, J. H., Smith, P. E., and Fleming, A. J.: Cardiac Vibrational Intensity and Cardiac Output. *Amer. Heart J. 35:* 953-961, 1948.
6. Hoffer, E. C.: Personal communication, 1969.
7. Johnston, F. D. and Overy, D. C.: Vibrations of Low Frequency over the Precordium. *Circ. 3:* 579-588, 1951.
8. Kaufman, S. S., Nims, L. F., Nyboer, J., and Somberg, H. M.: Applications of The Impedance

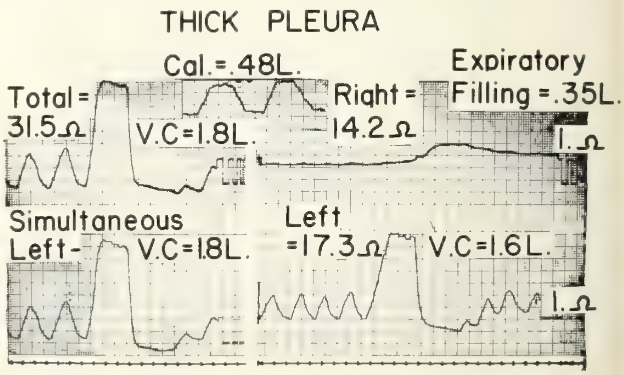


Fig. 13—Thick pleura really disturbs pulmonary function on the right as well as totally.

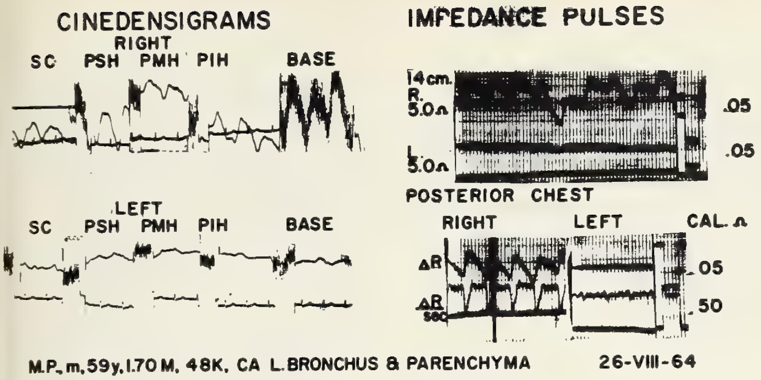


Fig. 14—Carcinoma seriously interferes with fluorodensigram pulsations as well as impedance pulsation of the affected left side.

Plethysmograph. National Research Council, Committee on Aviation Medicine Report, June, 1944.

9. Kneppo, A.: Personal communication, 1966.

10. Kourilsky, R., Marchal, M., and Marchal, M-T.: A New Method of Functional X-Ray Exploration of The Lungs. Photoelectric Stati-Densigraphy. *Dis. Chest 42:* 345-359, 1962.

11. Kubicek, W. G., Karnegis, J. N., Patterson, R. P., Witsoe, D. A., and Mattson, R. H.: Development and Evaluation of an Impedance Cardiac Output System. *Aerospace Med. 37:* 1208-1212, 1966.

12. Light, L. H.: Transcutaneous Observations of Blood Velocity in the Ascending Aorta in Man. Second World Congress on Ballistocardiography and Cardiovascular Dynamics, Oporto, Portugal, *Bibli Cardial 26:* 214-21, 1969.

13. Namon, R. and Gollan, F.: Resistive and Reactive Cardiac Impedance Pulses. First Symposium on Impedance Cardiography, NASA Manned Spacecraft Center, Houston, Texas, 1969.

14. Nyboer, J.: *Electrical Impedance Plethysmography* (second edition). Springfield, Illinois: Charles Thomas, 1970.

15. Nyboer, J.: Significance of Absolute Value Ballistocardiograms. Second World Congress on Ballistocardiography and Cardiovascular Dynamics, Oporto, Portugal. *Bibli Cardiol 26:* 147-151, 1969.

16. Thomassett, A.: Mesure du Volume des Liquides Extra-cellulaires par la Methode Electro-chimique. Signification Biophysique de L'Impedance a i Kilocycle du Corps Humain. *Lyon Med. 214.*

17. Williams, L. and Nyboer, J.: Experimental Study of Bilateral Pulmonary Function by Tetrapolar Electrical Impedance Spirometry. Unpublished study, 1966.

18. Zajic, F., Fejfar, Z., Franc, L., and Brod, J.: Impedance Plethysmograph. *Physiologia Bchemoslovenia 3:* 355-361, 1954.

PULMONARY & PULMONARY VASCULAR FUNCTIONS

Mean	Right	%	Left	%	Sum Total
Resistance Ohms	11.86	48	12.74	52	24.60
Tital Volume Liters	.37	52	.34	48	.71
Respiratory Rate / Minute	22.86	—	22.8	—	22.83
Resting Ventilation / Minute	7.86	52	7.23	48	15.09
Inspiratory Capacity, Liters	1.41	48	1.53	52	2.94
Expiratory Capacity, Liters	.116	47	.13	53	.246
Two Stage Capacity, Liters	1.51	46	1.66	54	3.27
Pulse Volume Liters	.028	49	.029	51	.057
Pulse Rate / Minute	76.	—	76.	—	76.
Pulse Volume / Minute	2.17	49	2.26	51	4.43

Fig. 15—Tabulation of 10 normal cases by impedance studies of right and left chest posteriorly after calibration by a wedge spirometer. The extrapolated impedance pulses apparently are also characteristic of right and left pulmonary blood flows. From an unpublished study by Williams and Nyboer.

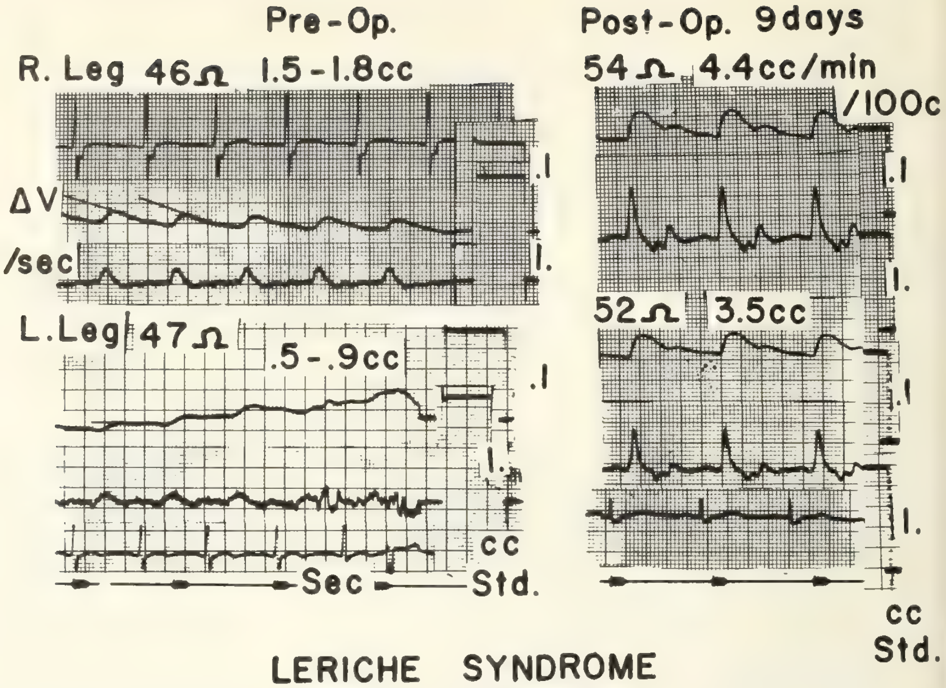
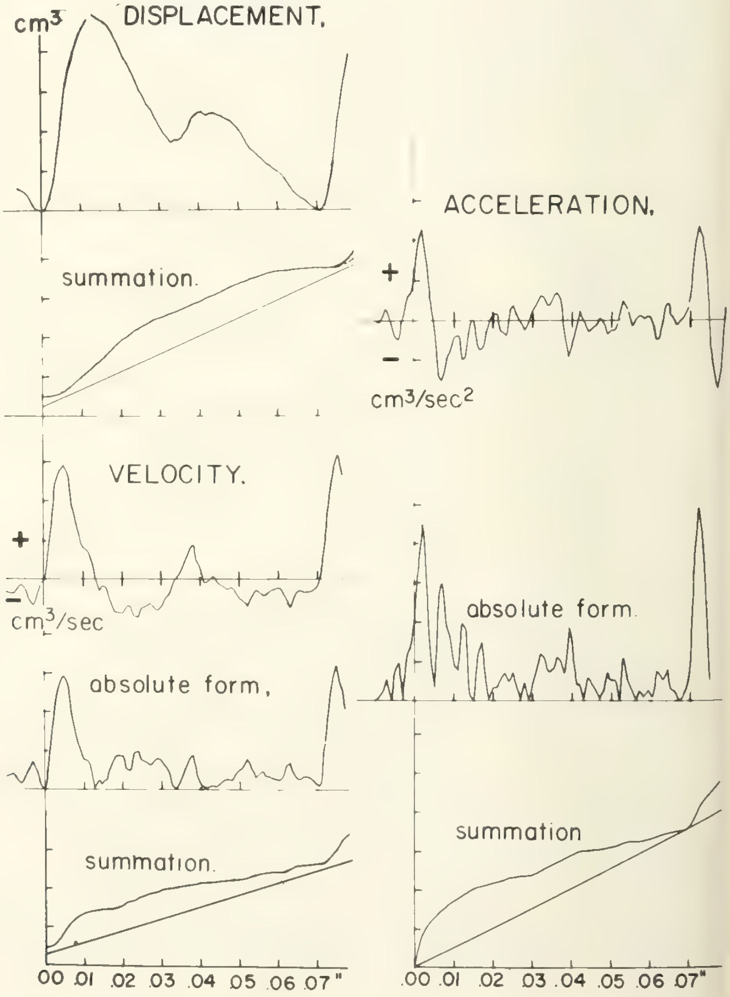


Fig. 16—The pulsations improve markedly following a bypass graft in Leriche Syndrome as recorded by electrical impedance plethysmography.

Fig. 17—Impedance volume pulsations may be computerized. The resultant curves in natural, absolute, and integrated forms are of real assistance in future impedance plethysmography. I was assisted by David Horowitz, E. E., Eaton, Yale, and Towne Incorp., in this study.



editorial viewpoints

Physicians Can Help Detect Diabetes

By James J. Aiuto, M.D., Chairman
Diabetes Detection Committee
Michigan Diabetes Association

In Michigan, we are joining with the American Diabetes Association in a nation-wide mass screening program during Diabetes Detection Week, November 15-21.

Last November, 47 Michigan hospitals joined with us in offering free post-prandial blood sugar tests during detection week. This year we expect an even greater number of hospitals to participate in the testing program.

However, this effort alone will not succeed in finding the estimated 100,000 "unknown" diabetics in Michigan.

WITH THE HELP of the communications media, attention will be focused on diabetes and the need for early detection of diabetes. Many people seeking tests may find no testing program available in their community. That is one reason we are calling on the local physician to join with us and provide a real service to patients, to the profession, and to the public, by testing his patients for diabetes during Detection Week.

No matter who provides the first stimulus for the diabetes program, it is ultimately the private physician whose active involvement and support determines the success of the program.

The Diabetes Detection Committee of the Michigan Diabetes Association (MDA) is concerned about reaching the high-risk segment of the population—the people who run the greatest danger of becoming diabetic. Certainly a program of diabetes control which seeks to uncover the greatest possible number of "hidden diabetics" in the population should begin by testing as many of these as possible. Persons most likely to be diabetic are over 40 years of age, obese, blood relatives of diabetics, mothers who have given birth to babies weighing 9 pounds or more at birth, women who have shown carbohydrate intolerance pregnancy, anyone who has demonstrated hyperglycemia on previous testing, and persons with other related chronic diseases.

Today, with the advance in effective methods of detection that are available to the physician, the control of diabetes is a real possibility and a great challenge.

DIABETES CAN BE DETECTED in its early stages. The basic objective of an effective program of diabetes control is to decrease the time interval between the onset of diabetes and its diagnosis, and to establish proper and adequate early treatment.

The Diabetes Detection Drive can succeed only with the cooperation of the practicing physician. He represents the first and main line of detection, as he is ultimately responsible for treatment. His help is essential if unknown diabetics are to be brought under medical care and thus remain effective members of the community. Physicians interested in participating may contact me at the Michigan Diabetes Association, 6131 West Outer Drive, Detroit 48235. Posters, pamphlets, and literature racks to provide visibility to the program are available at no charge, not only during Diabetes Week, but throughout the year.

What is Professionalism?

By Audrie W. Chute
Editor, **Bulletin**
Michigan State Medical Assistants

This article, reprinted from the Michigan State Medical Assistants' Society's BULLETIN, demonstrates the appeal to high standards and excellence in service which the organization makes to its members.

What is the hallmark of a professional? Webster tells us that the word "professional" is "characteristic of, or conforming to the technical or ethical standards of a profession or an occupation regarded as such."

Willard L. Sperry, Dean of Harvard Divinity School, says, "The prime social reason for the existence of a profession is the service it can render to humanity." In our roles as medical assistants, we render service to both the doctors and the patients. While basic knowledge must be acquired—advanced learning and techniques—in any profession, isn't there something else that needs to be acquired?

What is professionalism? Is it a mythical atti-

(Continued on Page 1002)

tude, conduct, or quality? Is it what one hopes to project as the image of his profession?

The dictionary defines professionalism as "conduct, aims, qualities, etc., characteristic of, or peculiar to a profession." A code of professional ethics or conduct is the voluntary assumption of self-discipline beyond that required by law. Professionalism is a standard of conduct that must be adhered to by those individuals who wish to be a part of the paramedical profession. With the development of such standards of conduct, the positive image results. That professionalism is projected in our relationship with the public—the patients—our most important area of influence. Service, education, professional standards of conduct, and self-disciplinary measures are fundamental attributes that characterize a profession.

Professionalism goes beyond our service to our employer, the physician, and the patients whom we serve, to our association with the members of our societies, collectively and individually. A self-disciplinary system must be developed to enforce those attributes of professionalism in all our relationships in our organization.

In our associations as medical assistants, this—call it professionalism or a challenge—is the best selling point to the general public, to the doctor-employer, and to increasing the interest and cohesiveness in our state and county societies.

MAILBAG

Doctor Gronvall Expresses Gratitude For MSMS Gift

Robert J. Mason, M.D.
Immediate Past President
Michigan State Medical Society

Dear Dr. Mason:

I want to thank you for your public presentation and acknowledgment of the gift of $11,145 made to The University of Michigan Medical School through the AMA-ERF campaign. I thought your comments to the House of Delegates of the State Society were helpful in calling attention to the importance of this campaign.

You know, of course, how helpful these funds are to the Medical School. They allow us to capitalize quickly on opportunities which would often be lost if we had to depend only on the categorical funds from legislative appropriations and research grants and contracts. We do sincerely appreciate the interest and efforts of the Society in this regard.

Sincerely yours,
John A. Gronvall, M.D.
Acting Dean

MICHIGAN
DEPARTMENT
OF PUBLIC
HEALTH

Monthly Surveillance Report

Cases of Certain Diseases Reported
To the Michigan Department of Public Health

For the Five-Week Period Ending October 2, 1970

	1970 This 5-Week Period	1969 Same 5-Week Period	1970 Total To Above Date	1969 Total Same Date	Total Cases for 1969
Rubella	79	89	2700	3825	4307
Congenital Rubella Syndrome	—	—	—	—	—
Measles	43	37	1725	295	401
Whooping Cough	31	41	153	128	192
Diphtheria	—	—	—	—	—
Mumps					
Scarlet Fever &	154	100	5059	4004	5215
Strep Sore Throat	432	406	8621	6859	9763
Tetanus	0	1	4	4	6
Poliomyelitis (paralytic)	0	0	1	0	0
Hepatitis	436	329	3475	2381	3360
Salmonellosis (other than S. typhi)	68	53	500	412	539
Typhoid Fever (S. typhi)	3	0	11	4	6
Shigellosis	17	36	151	220	300
Aseptic Meningitis	109	45	209	116	179
Encephalitis	20	21	108	95	120
Meningococcic Meningitis	6	1	55	93	114
H. Influenza Meningitis	0	3	37	44	56
Tuberculosis	155	140	1534	1633	2108
Syphilis	350	342	2883	3199	4021
Gonorrhea	2209	2323	15774	14338	19194

Information can be supplied by the local health department on the local incidence of disease.

Maurice Reizen, M.D., Director
Michigan Department of Public Health

CALORIES / 7 oz. Serving*

Beef Broth	22	Vegetable	68
Consommé	29	Tomato	69
Chicken with Rice	43	Cream of Asparagus	70
Chicken Gumbo	48	Cream of Chicken	76
Chicken Noodle	54	Cream of Mushroom	115
Cream of Potato	58	Green Pea	116
Chicken Vegetable	60	Cream of Shrimp (Frozen)	132
Vegetable Beef	66	Bean with Bacon	133

In planning high or low calorie diets, Campbell's more than 50 different soups offer you a wide choice. And, most of Campbell's Soups contain a wide variety of ingredients that can serve as supplementary sources of many essential nutrients.

* From "Nutritive Composition of Campbell's Products" which gives values of important nutritive constituents of all Campbell's Products. For your copy, write to Campbell Soup Company, Dept. 536, Camden, New Jersey 08101.

here's a soup
for almost every patient and diet
..for every meal
and, it's made by Campbell

A fresh Choice
in oral contraception
Dem/ulen®
Each tablet contains 1 mg. ethynodiol diacetate/50 mcg. ethinyl estradiol

A distinctive combination containing 1 mg. of ethynodiol diacetate, Searle's unique progestin with an unmatched record of acceptance in oral contraception, and 50 mcg. of ethinyl estradiol. The same low incidence of breakthrough bleeding and of other side effects you have come to appreciate with ethynodiol diacetate and mestranol plus all the convenient dosage schedule and packaging features you expect from Searle. The choice is yours!

A fresh Choice

in oral contraception

Demulen®

Each tablet contains 1 mg ethynodiol diacetate/50 mcg ethinyl estradiol

Actions—Demulen acts to prevent ovulation by inhibiting the output of gonadotropins from the pituitary gland. Demulen depresses the output of both the follicle-stimulating hormone (FSH) and the luteinizing hormone (LH).

Special note: Oral contraceptives have been marketed in the United States since 1960. Reported pregnancy rates vary from product to product. The effectiveness of the sequential products appears to be somewhat lower than that of the combination products. Both types provide almost completely effective contraception.

An increased risk of thromboembolic disease associated with the use of hormonal contraceptives has now been shown in studies conducted in both Great Britain and the United States. Other risks, such as those of elevated blood pressure, liver disease and reduced tolerance to carbohydrates, have not been quantitated with precision. Long-term administration of both natural and synthetic estrogens in subprimate animal species in multiples of the human dose increases the frequency of some animal carcinomas. These data cannot be transposed directly to man. The possible carcinogenicity due to the estrogens can be neither affirmed nor refuted at this time. Close clinical surveillance of all women taking oral contraceptives must be continued.

Indication—Demulen is indicated for oral contraception.

Contraindications—Patients with thrombophlebitis, thromboembolic disorders, cerebral apoplexy or a past history of these conditions, markedly impaired liver function, known or suspected carcinoma of the breast, known or suspected estrogen-dependent neoplasia and undiagnosed abnormal genital bleeding.

Warnings—The physician should be alert to the earliest manifestations of thrombotic disorders (thrombophlebitis, cerebrovascular disorders, pulmonary embolism and retinal thrombosis). Should any of these occur or be suspected the drug should be discontinued immediately.

Retrospective studies of morbidity and mortality in Great Britain and studies of morbidity in the United States have shown a statistically significant association between thrombophlebitis, pulmonary embolism, and cerebral thrombosis and embolism and the use of oral contraceptives. There have been three principal studies in Britain[1-3] leading to this conclusion, and one[4] in this country. The estimate of the relative risk of thromboembolism in the study by Vessey and Doll[3] was about sevenfold, while Sartwell and associates[4] in the United States found a relative risk of 4.4, meaning that the users are several times as likely to undergo thromboembolic disease without evident cause as nonusers. The American study also indicated that the risk did not persist after discontinuation of administration, and that it was not enhanced by long-continued administration. The American study was not designed to evaluate a difference between products. However, the study suggested that there might be an increased risk of thromboembolic disease in users of sequential products. This risk cannot be quantitated, and further studies to confirm this finding are desirable.

Discontinue medication pending examination if there is sudden partial or complete loss of vision, or if there is a sudden onset of proptosis, diplopia or migraine. If examination reveals papilledema or retinal vascular lesions medication should be withdrawn.

Since the safety of Demulen in pregnancy has not been demonstrated, it is recommended that for any patient who has missed two consecutive periods pregnancy should be ruled out before continuing the contraceptive regimen. If the patient has not adhered to the prescribed schedule the possibility of pregnancy should be considered at the time of the first missed period.

A small fraction of the hormonal agents in oral contraceptives has been identified in the milk of mothers receiving these drugs. The long-range effect to the nursing infant cannot be determined at this time.

Precautions—The pretreatment and periodic physical examinations should include special reference to the breasts and pelvic organs, including a Papanicolaou smear, since estrogens have been known to produce tumors, some of them malignant, in five species of subprimate animals. Endocrine and possibly liver function tests may be affected by treatment with Demulen. Therefore, if such tests are abnormal in a patient taking Demulen, it is recommended that they be repeated after the drug has been withdrawn for two months. Under the influence of progestogen-estrogen preparations preexisting uterine fibromyomas may increase in size. Because these agents may cause some degree of fluid retention, conditions which might be influenced by this factor, such as epilepsy, migraine, asthma, cardiac or renal dysfunction, require careful observation. In breakthrough bleeding, and in all cases of irregular bleeding per vaginam, nonfunctional causes should be borne in mind. In undiagnosed bleeding per vaginam adequate diagnostic measures are indicated. Patients with a history of psychic depression should be carefully observed and the drug discontinued if the depression recurs to a serious degree. Any possible influence of prolonged Demulen therapy on pituitary, ovarian, adrenal, hepatic or uterine function awaits further study. A decrease in glucose tolerance has been observed in a significant percentage of patients on oral contraceptives. The mechanism of this decrease is obscure. For this reason, diabetic patients should be carefully observed while receiving Demulen therapy. The age of the patient constitutes no absolute limiting factor, although treatment with Demulen may mask the onset of the climacteric. The pathologist should be advised of Demulen therapy when relevant specimens are submitted. Susceptible women may experience an increase in blood pressure following administration of contraceptive steroids.

Adverse reactions observed in patients receiving oral contraceptives—A statistically significant association has been demonstrated between use of oral contraceptives and the following serious adverse reactions: thrombophlebitis, pulmonary embolism and cerebral thrombosis.

Although available evidence is suggestive of an association, such a relationship has been neither confirmed nor refuted for the following serious adverse reactions; neuro-ocular lesions, e.g., retinal thrombosis and optic neuritis.

The following adverse reactions are known to occur in patients receiving oral contraceptives: nausea, vomiting, gastrointestinal symptoms (such as abdominal cramps and bloating), breakthrough bleeding, spotting, change in menstrual flow, amenorrhea during and after treatment, edema, chloasma or melasma, breast changes (tenderness, enlargement and secretion), change in weight (increase or decrease), changes in cervical erosion and cervical secretions, suppression of lactation when given immediately post partum, cholestatic jaundice, migraine, rash (allergic), rise in blood pressure in susceptible individuals and mental depression.

Although the following adverse reactions have been reported in users of oral contraceptives, an association has been neither confirmed nor refuted: anovulation post treatment, premenstrual-like syndrome, changes in libido, changes in appetite, cystitis-like syndrome, headache, nervousness, dizziness, fatigue, backache, hirsutism, loss of scalp hair, erythema multiforme, erythema nodosum, hemorrhagic eruption and itching.

The following laboratory results may be altered by the use of oral contraceptives: hepatic function: increased sulfobromophthalein retention and other tests; coagulation tests: increase in prothrombin, Factors VII, VIII, IX and X; thyroid function: increase in PBI and butanol extractable protein bound iodine, and decrease in T^3 uptake values; metyrapone test and pregnanediol determination.

References: 1. Royal College of General Practitioners: Oral Contraception and Thrombo-Embolic Disease, J. Coll. Gen. Pract. *13*: 267-279 (May) 1967. *2.* Inman, W. H. W., and Vessey, M. P.: Investigation of Deaths from Pulmonary, Coronary, and Cerebral Thrombosis and Embolism in Women of Child-Bearing Age, Brit. Med. J. *2*:193-199 (April 27) 1968. *3.* Vessey, M. P., and Doll, R.: Investigation of Relation Between Use of Oral Contraceptives and Thromboembolic Disease. A Further Report, Brit. Med. J. *2*:651-657 (June 14) 1969. *4.* Sartwell, P. E.; Masi, A. T.; Arthes, F. G.; Greene, G. R., and Smith, H. E.: Thromboembolism and Oral Contraceptives: An Epidemiologic Case-Control Study, Amer. J. Epidem. *90*:365-380 (Nov.) 1969.

0A4

SEARLE

Where "The Pill" Began
G. D. Searle & Co., P.O. Box 5110, Chicago, Illinois 60680

Mylanta®
24 million hours a day.

Through the day, every day,
ulcer patients take
one million doses of Mylanta
for relief of ulcer pain.

Mylanta®
LIQUID/TABLETS
aluminum and magnesium hydroxides plus simethicone

Good taste = patient acceptance
Relieves G.I. gas distress*
Non-constipating

*with the defoaming action of simethicone

Stuart
PHARMACEUTICALS Pasadena, Calif. 91109
Division of Atlas Chemical Industries, Inc., Wilmington, Del. 19899

A
BUILDING BLOCK
TO RECOVERY

"Welcome back, Ann"
As adjunctive therapy
DOUBLE STRENGTH
Orenzyme®
Bitabs
One tablet q.i.d.
Trypsin 100,000 N.F. Units, Chymotrypsin: 8,000 N.F. Units; equivalent in tryptic activity to 40 mg. of N.F. trypsin
Reduces swelling
Hastens healing
Speeds recovery
trauma
One tablet q.i.d.

Indications: When used as adjunctive therapy for the rapid resolution of inflammation and edema, good results have been obtained in:
☐ Accidental Trauma ☐ Postoperative Tissue Reactions.
Other conventional measures of treatment should be used as indicated. In infection, appropriate anti-infective therapy should be given.
Contraindications: ORENZYME BITABS should not be given to patients with a known sensitivity to trypsin or chymotrypsin.
Precautions: It should be used with caution in patients with abnormality of the blood clotting mechanism such as hemophilia, or with severe hepatic or renal disease. Safe use in pregnancy has not been established.
Adverse Reactions: Adverse reactions with ORENZYME have been reported infrequently. Reports include allergic manifestations (rash, urticaria, itching), gastrointestinal upset and increased speed of dissolution of animal-origin surgical sutures. There have been isolated reports of anaphylactic shock, albuminuria and hematuria. Increased tendency to bleed has also been reported but, in controlled studies, it has been seen with equal incidence in placebo-treated groups. (See Precautions.) It is recommended that if side effects occur medication be discontinued.
Dosage: One tablet q.i.d.

THE NATIONAL DRUG COMPANY
DIVISION OF RICHARDSON-MERRELL INC.
PHILADELPHIA, PENNSYLVANIA 19144
TRADEMARK BITABS U S PATENT NO 3,004,893 9/70 0-009A 161

Orenzyme® Bitabs

Trypsin: 100,000 N.F. Units, Chymotrypsin: 8,000 N.F. Units; equivalent in tryptic activity to 40 mg. of N.F. trypsin

The causes of vaginitis are multiple

Trichomonads . . . monilia . . . bacteria
You can depend on AVC—comprehensive therapy that combats all three major vaginal pathogens, alone or in combination.

AVC
Cream (aminacrine hydrochloride 0.2%, sulfanilamide 15.0%, allantoin 2.0%)

Suppositories (aminacrine hydrochloride 0.014 Gm., sulfanilamide 1.05 Gm., allantoin 0.14 Gm.)

Contraindications: Known sensitivity to sulfonamides.
Precautions/Adverse Reactions: The usual precautions for topical and systemic sulfonamides should be observed because of the possibility of absorption. Burning, increased local discomfort, skin rash, urticaria or other manifestations of sulfonamide toxicity are reasons to discontinue treatment.
Dosage: One applicatorful or one suppository intravaginally once or twice daily.
Supplied: Cream – Four-ounce tube with or without applicator. Suppositories – Box of 12 with applicator.

TRADEMARK: AVC AV-007A 7/70 Y-149

THE NATIONAL DRUG COMPANY
DIVISION OF RICHARDSON-MERRELL INC
PHILADELPHIA, PENNSYLVANIA 19144

AVC
The treatment is singular

Smiles speak louder than words
for the good taste of Soyalac

Milk-free, hypo-allergenic Soyalac has a pleasing taste that is eagerly accepted by most infants. It's similar to mother's milk in composition and assimilation, much like cow's milk in consistency and completely free of fibre. Extensive clinical data support Soyalac's value in promoting growth and development. Soyalac is also excellent for growing children and adults.

Loma Linda
Soyalac
CONCENTRATED
LIQUID
Hypoallergenic
For Infants
Children and Adults

Available in
Concentrated Liquid or Powdered

Free Booklet and Samples

A request on your professional letterhead or prescription form will bring to you complete information and a supply of samples.

Soyalac

a product of
LOMA LINDA FOODS
MEDICAL PRODUCTS DIVISION
RIVERSIDE, CALIFORNIA
Mount Vernon, Ohio, U.S.A.

CONSTIPATION
EVACUATE GENTLY

With EVAC-U-GEN — your patients with functional constipation can evacuate gently. Because EVAC-U-GEN has a mild laxative action and tends to cause the stool to be soft — it is highly desirable for those sensitive to harsh laxatives — particularly children, pregnant women, and geriatric patients. Recommend EVAC-U-GEN for the management of functional constipation. It is highly effective. Non-griping. Chewable. Very palatable. Economical.

EVAC-U-GEN®

A highly-flavored and palatable tablet of yellow phenolphthalein, bismuth subcarbonate, bismuth subgallate in special base. Chewable. Bottles of 35 and 100. Adult Dose: Chew 1 or 2 tablets night or morning. Children (up to age 10): ½ tablet. A citrus drink taken with tablet will stimulate action.
PRECAUTION: Do not use when symptoms of appendicitis are present and discontinue use if skin rash appears. Dependence on laxatives can result from continued use.

W-C
PRECISION PHARMACEUTICALS

SEND FOR SAMPLES.
WALKER, CORP & CO., INC.
Syracuse, New York 13201

environment and health

"The Michigan State Medical Society strongly backs the current efforts being made in the fight to improve our environmental health. As physicians and citizens we realize the urgent necessity in curbing environmental pollution whatever its origin."

That was the conviction expressed by MSMS in July, 1970, through a Statement on Environmental Pollution published in MICHIGAN MEDICINE. To keep the issue ever before the concerned minds of Michigan's physicians, the MSMS Committee on Public Health maintains this page on the environment and health.

This month, the Committee presents the following list of national organizations which may be contacted by the interested physician:

Organizations Involved in Water Pollution Control

Friends of the Earth
30 E. 42nd St.
New York, New York 10017

National Audubon Society
1130 5th Avenue
New York, New York 10028

UAW-CIO Dept. of Conservation and Resource Development
8000 E. Jefferson
Detroit, Michigan 48214

American Fisheries Society
719 13th St. N.W.
Washington, D.C. 20005

Trout Unlimited
900 Lapeer Avenue
Saginaw, Michigan 48607

Wildlife Management Institute
709 Wire Bldg.
Washington, D.C. 20005

Sport Fishing Institute
719 13th St. N.W.
Washington, D.C. 20005

Wildlife Society
1734 N Street N.W.
Washington, D.C. 20006

Conservation Foundation
1250 Connecticut Avenue
Washington, D.C. 20036

Sierra Club
1050 Mills Tower
San Francisco, California

New Series to Explain Health Care Aid Programs In Detail

Several governmental agencies are providing a variety of medical, health and hospital care programs for the people of Michigan who may not be aware that such assistance is available. These programs differ in requirements for eligibility, income allowances, family limits, etc., which makes it difficult for the physician to supply accurate information to his patients.

In the January issue of *Michigan Medicine,* the first of a series of articles will appear explaining the several health care assistance programs to the physician, enabling him to provide accurate information if his patient requests assistance.

Some of the important, but lesser known programs, i.e., CHAMPUS, eligibility requirements in public health service hospitals, etc., will also be fully explained.

It is suggested that physicians and their medical assistants become knowledgeable about these programs and retain these articles as a reference manual.

Pertinent changes in rules and regulations will be noted as they occur.

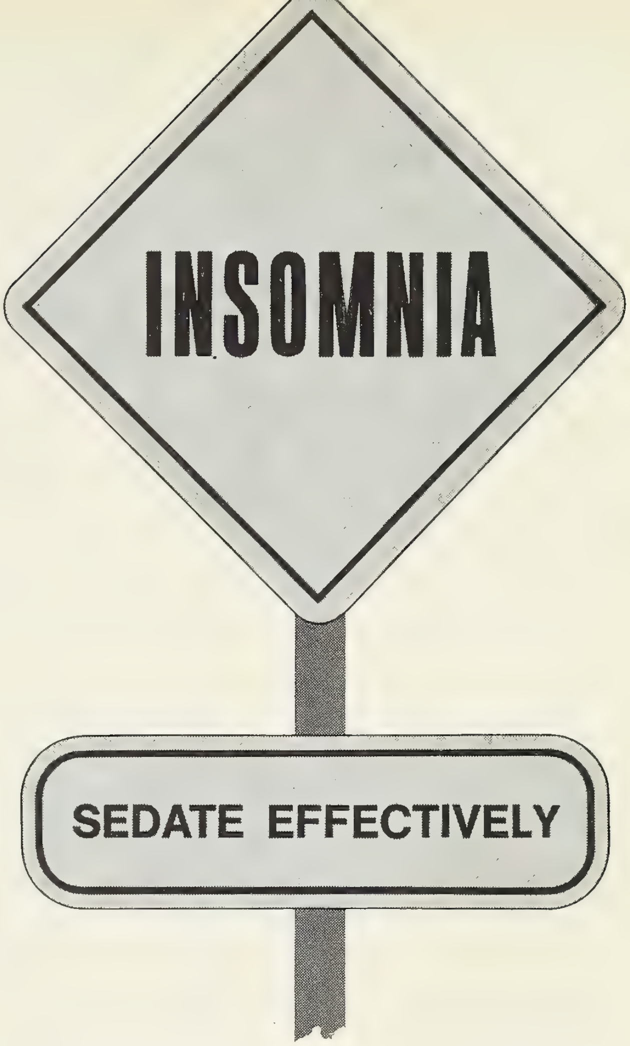
Physicians are invited to submit additional informational requests by writing MSMS.

MAP Selects 1970-71 Officers

George B. Savage, AIA, Grand Rapids, is new president of the Michigan Association of the Professions. He succeeds Charles H. King, J.D., of Detroit.

Other new officers of MAP are Harold D. Sheridan, D.V.M., of Coopersville, vice president; J. Russell Brink, M.D., Grand Rapids, secretary, and Douglas M. Ammons, R.Ph., Lansing, treasurer.

New members of the MAP Board of Directors are Roy L. Bovee, R.Ph., Lansing; Lehmann M. Dunn, P.E., Port Huron; Bradley M. Harris, M.D., Ypsilanti; Melvin Leasure, M.A., Madison Heights; Warren E. Poole, A.I.A., Ann Arbor; William R. Shaw, C.P.A., Detroit, and Samuel E. Vitale, C.P.A., Saginaw.



With QUĪ-A-ZONE — you can sedate effectively. A balanced combination of short, intermediate, and long-acting barbiturates (totaling 100 mg.) in a rapidly disintegrating tablet — sedation is provided within a few minutes . . . followed by sound restful sleep . . . usually without morning hangover. The four barbiturates in QUĪ-A-ZONE have dual channels of elimination (renal and hepatic) to lessen metabolic burden, decrease barbiturate retention, and minimize depression.

QUĪ-A-ZONE™

Each rapidly-disintegrating tablet contains 25 mg. secobarbital, 25 mg. pentobarbital, 25 mg. butabarbital, and 25 mg. phenobarbital. Bottles of 100.
Usual Adult Dose: 1 to 2 tablets before retiring.
PRECAUTION: Should not be administered to patients sensitive to barbiturates, or in cases of known previous addiction. Warning: May be habit forming.

W-C PRECISION PHARMACEUTICALS

SEND FOR SAMPLES.

WALKER, CORP & CO., INC.
Syracuse, New York 13201

Gone with the wind

The gas/acid group of disorders

"The two most common complaints referable to the upper gastrointestinal tract for which patients seek medical relief are hyperacidity and 'gas.' The two often occur together."*

Frees captured gas...neutralizes free acid

Silain-Gel Tablets and Liquid are separate formulas designed to provide equivalent dual-action symptomatic relief. Both dosage forms contain simethicone which effectively frees trapped gas, enabling the patient to eliminate it. Magnesium hydroxide in both assures a rapid rise in pH for prompt relief of hyperacidity. The special co-dried aluminum hydroxide/magnesium carbonate gel in the tablets assures the same rapid and uniform reaction rate as the liquid. Thus, both medications achieve prompt and prolonged neutralization of free acid *plus* prompt relief from the pain and pressure of trapped gas.

Always in good taste

The pleasant, distinctive flavor of Silain-Gel, as well as its non-constipating feature, make it a therapy your patients can live with—in comfort and without complaint.

Select the form of Silain-Gel you want to provide symptomatic relief in: gastric ulcer • duodenal ulcer • heartburn • gastric hyperacidity • gastritis • dyspepsia

when the patient prefers the convenience of a tablet, select

Silain-Gel® Tablets:

when the patient prefers a liquid, select

Silain-Gel® Liquid

Also available for the patient who needs an antifrothicant/antiflatulent agent only: **Silain®** (simethicone) Tablets

Slanger, A.: Med. Times *94*:150 (Feb.) 1966.

Announcing the "Antgasid"

Silain-Gel®

Tablets: simethicone plus aluminum hydroxide/magnesium carbonate co-dried gel and magnesium hydroxide

Liquid: simethicone plus aluminum hydroxide and magnesium hydroxide

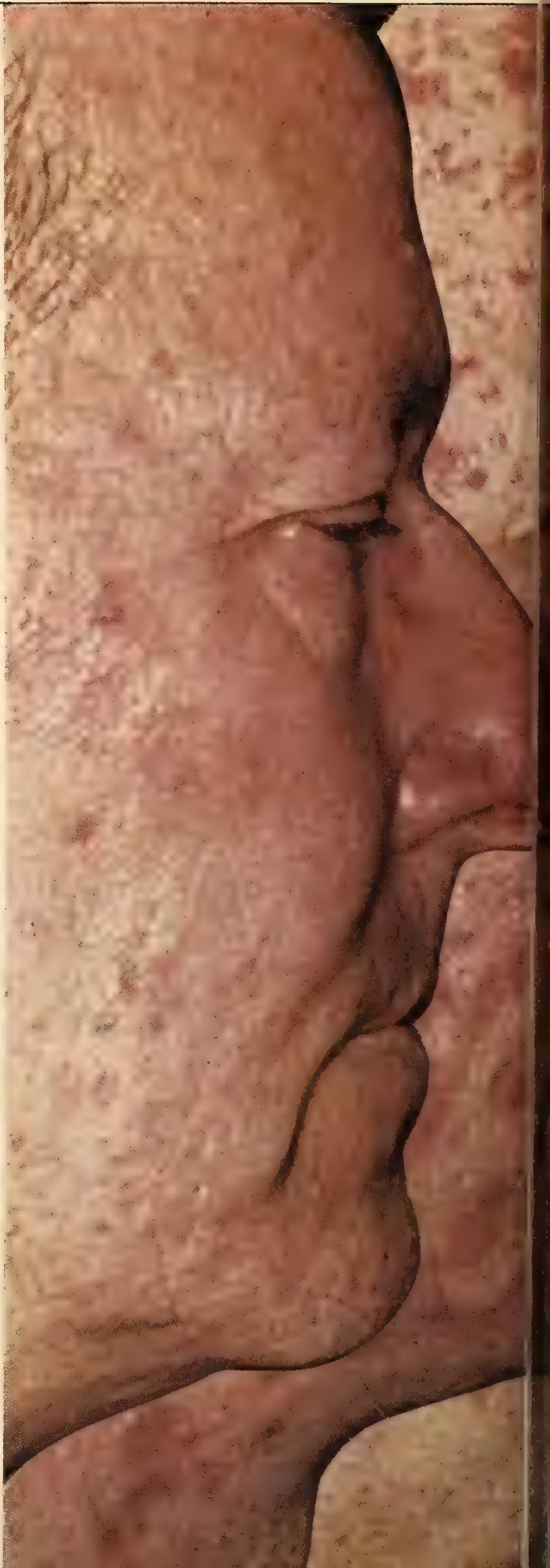
ne dose does both: frees captured gas...neutralizes free acid

A·H·ROBINS A.H. Robins Company, Richmond, Virginia 23220

Roche announces Efudex® (fluorouracil) cream/solution

for the treatment of solar/actinic keratoses... a topical alternative to conventional therapy

1/22/68—Treatment with 5% 5-FU cream commences. Patient K.L. showing widespread but mild solar keratoses (also known as actinic keratoses).



Fluorouracil—the Roche contribution

In 1962, Roche Laboratories introduced Fluorouracil Roche® (5-fluorouracil). Early clinical work with this drug suggested that it possessed a selective cytotoxic activity when applied topically to certain kinds of lesions. Based on this work and years of clinical trials, a standardized form of topical fluorouracil can now be recommended for treatment of multiple solar or actinic keratoses.

Efudex® (fluorouracil)—a new alternative to conventional therapy

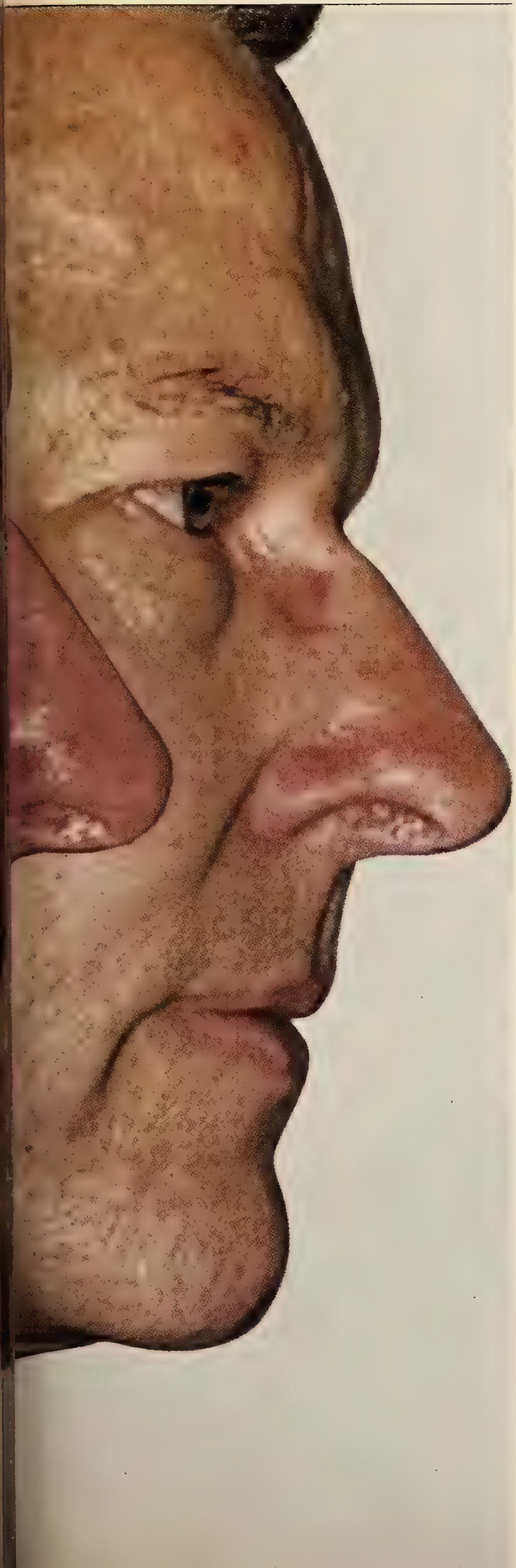
Efudex presents the physician with a topical alternative to surgery in the treatment of solar or actinic keratoses. It is effective, comparatively inexpensive and especially well-suited for treatment of multiple lesions. Important, too, is the highly desirable cosmetic result. Clinical experience demonstrates that treatment with Efudex results in an extremely low incidence of scarring.*

Highly effective on first and later applications

In clinical trials, depending on the dosage form and strength used, complete involution occurred in 77 to 88 per cent of lesions following treatment. The rate of recurrence was low, ranging from 1.7 to 5.6 per cent up to a year after completion of therapy. When lesions did recur or new ones appeared, repeated courses of Efudex therapy proved effective.*

2/68—After 11 days of treatment. ythema is seen at site of keratoses. In dition, numerous lesions not apparent ior to therapy have become manifest sharply defined reactions. Intervening in, also treated, shows no response to erapy.

19/69—One year after cessation of erapy. Skin appears clear with no evi- nce of scarring. Examination reveals k of recurrence or the formation of w lesions.



Predictable sequence of therapeutic response

Two to four weeks constitutes a typical course of Efudex therapy. The response is usually characteristic and predictable. After three or four days of treatment, erythema begins to appear in the area of the keratoses. This is followed by an intense inflammatory response, scaling and occasionally moderate tenderness or pain. The height of the inflammatory reaction generally occurs two weeks after the start of therapy, and then begins to subside as treatment is stopped. Within two weeks of discontinuing medication, the inflammation is usually gone. A mild erythema may remain for two to three months before gradually receding.

Selective—with a high degree of safety

Despite the temporary unsightliness and discomfort of the inflammatory episode, Efudex is, in general, more readily tolerated than surgery. Clinical work shows the intense inflammatory response to be limited to the area of the lesion. Normal skin is not similarly affected. Another measure of Efudex safety: systemic absorption of topical fluorouracil was insignificant, indicating a low risk of systemic toxicity.*

Two strengths—two convenient dosage forms

Efudex is available as a 2% or 5% solution or as a 5% cream. It is applied twice daily by the patient with a nonmetal applicator or suitable glove.

Before prescribing Efudex, however, there are two important considerations. First, please consult the complete prescribing information for precautions, warnings and adverse reactions. Second, advise the patient that treated lesions should respond with the characteristic but transient inflammation. A positive sign that Efudex is working for them.

*Data on file, Hoffmann-La Roche Inc., Nutley, New Jersey.

2% and 5% Solutions; 5% Cream Applied twice daily—resolves solar or actinic keratoses.

new
Efudex®
(fluorouracil)
cream/solution

For full prescribing information, please see the following page.

Roche introduces

Efudex®

(fluorouracil) cream/solution the new standardized topical for solar/actinic keratoses

Description: Efudex solutions and cream are topical preparations containing the fluorinated pyrimidine 5-fluorouracil, an antineoplastic antimetabolite.

Efudex Solution consists of 2% or 5% fluorouracil on a weight/weight basis, compounded with propylene glycol, tris-(hydroxymethyl) aminomethane, hydroxypropyl cellulose, parabens (methyl and propyl) and disodium edetate.

Efudex Cream contains 5% fluorouracil in a vanishing cream base consisting of white petrolatum, stearyl alcohol, propylene glycol, polysorbate 60 and parabens (methyl and propyl).

Actions: There is evidence that the metabolism of fluorouracil in the anabolic pathway blocks the methylation reaction of deoxyuridylic acid to thymidylic acid. In this fashion fluorouracil interferes with the synthesis of deoxyribonucleic acid (DNA) and to a lesser extent inhibits the formation of ribonucleic acid (RNA). Since DNA and RNA are essential for cell division and growth, the effect of fluorouracil may be to create a thymine deficiency which provokes unbalanced growth and death of the cell. The effects of DNA and RNA deprivation are most marked on those cells which grow more rapidly and which take up fluorouracil at a more rapid pace. The catabolic metabolism of fluorouracil results in degradative products (*e.g.*, CO_2, urea, α-fluoro-β-alanine) which are inactive.

Studies in man with topical application of ^{14}C-labeled Efudex demonstrated insignificant absorption as measured by ^{14}C content of plasma, urine and respiratory CO_2.

Indications: Efudex is recommended for the topical treatment of multiple actinic or solar keratoses.

Contraindications: Efudex is contraindicated in patients with known hypersensitivity to any of its components.

Warnings: If an occlusive dressing is used, there may be an increase in the incidence of inflammatory reactions in the adjacent normal skin.

Prolonged exposure to ultraviolet rays should be avoided while under treatment with Efudex because the intensity of the reaction may be increased.

Usage in Pregnancy: Safety for use in pregnancy has not been established.

Precautions: If Efudex is applied with the fingers, the hands should be washed immediately afterward. Efudex should be applied with care near the eyes, nose and mouth. To rule out the presence of a frank neoplasm, a biopsy should be made of those areas failing to respond to treatment or recurring after treatment.

Adverse Reactions: The most frequently encountered local reactions were pain, pruritus, hyperpigmentation and burning the site of application. Other local reactions included dermatit scarring, soreness and tenderness.

Also reported were insomnia, stomatitis, suppuration, scalin swelling, irritability, medicinal taste, photosensitivity and lacrimation.

Laboratory abnormalities reported were leukocytosis, thrombocytopenia, toxic granulation and eosinophilia.

Dosage and Administration: Efudex should be applied twice da with a nonmetal applicator or suitable glove in an amount of t solution or cream sufficient to cover the lesion. When Efudex i applied to a lesion, a response occurs with the following seque erythema, usually followed by vesiculation, erosion, ulceratio necrosis and epithelization. The lower frequency and intensity activity in adjacent normal skin indicate a selective cytotoxic property. Medication should be continued until the inflammato reaction reaches the erosion, necrosis and ulceration stage, at which time use of the drug should be terminated. The usual duration of therapy is from 2 to 4 weeks. Complete healing of th lesion may not be evident for 1 to 2 months following cessation Efudex therapy.

How Supplied: Efudex Solution, 10-ml drop dispensers—contai 2% or 5% fluorouracil on a weight/weight basis, compounded with propylene glycol, tris(hydroxymethyl)aminomethane, hydroxypropyl cellulose, parabens (methyl and propyl) and disodium edetate.

Efudex Cream, 25-Gm tubes—containing 5% fluorouracil in vanishing cream base consisting of white petrolatum, stearyl alcohol, propylene glycol, polysorbate 60 and parabens (methy and propyl).

Clinical Studies: The effectiveness of the three preparations a determined by complete involution of solar keratoses was: 2% Solution, 77% of 282 lesions; 5% Solution, 88% of 202 lesions; and 5% Cream, 85% of 189 lesions. In those lesions wh complete involution followed treatment, the rate of possible recurrences observed clinically at periods up to 12 months or m was: 2% Solution, 4.6% of 218 lesions; 5% Solution, 1.7% of 1 lesions; and 5% Cream, 5.6% of 160 lesions. Because of the toxi potential of fluorouracil, some physicians preferred to use the 2 solution when large areas were to be treated. Approximately 30 of the lesions required treatment for two weeks or less; approximately 78% required four weeks or less for adequate treatment.

ROCHE
Roche
LABORATORIES
Division of Hoffmann-La Roche Inc
Nutley, New Jersey 07110

about doctors

Harold L. Fachnie, M.D., Detroit,
recently received a silver tray in recognition of "excellent services rendered the Department of Gynecology and Obstetrics at the WSU School of Medicine as resident, instructor and assistant professor from 1952-1970." The tray was presented by Charles S. Stevenson, M.D., who has formed an Old Residents' Society with the 59 men and 5 women who were appointed to resident training during Doctor Stevenson's tenure as chairman of the WSU department from 1948 through 1961. Doctor Stevenson has been honored by the Old Residents' Society through the establishment of the Charles S. Stevenson Prize Award to be presented annually to the senior medical student who excels in gynecology and obstetrics at WSU.

Edward O. Willoughby, M.D.,
formerly of Hines, Ill., is a new medical consultant in the Michigan Bureau of Medical Care Administration. He has responsibility for the administration of the Medical Review and Nursing Evaluation Program for clients of the Department of Social Services receiving care in the state's nursing homes, and medical care facilities.

Homer Stryker, M.D., Kalamazoo,
received the Distinguished Alumni Award from Western Michigan University during commencement exercises Aug. 14.

Maynard Conrad, M.D., Kalamazoo,
is a board trustee of the Kalamazoo College Alumni Association. He was formerly president of the organization from 1966-68.

Coming Features . . .

In the December issue of *Michigan Medicine,* look for the second article in the series reporting the findings of the MARMP study of physicians' postgraduate medical education needs; further pictures from the 1970 MSMS Annual Session, and important scientific articles.

James C. Cook, M.D., Detroit,
has just completed a one-year term of office as president of the American Roentgen Ray Society. Doctor Cook is also chairman of the board of the Michigan Cancer Foundation.

Alex S. Friedlaender, M.D., Detroit,
assumes duties this month as president-elect of the American Association for Clinical Immunology and Allergy. His one-year term as president will begin at the AACIA's annual meeting in November, 1971. Doctor Friedlaender is past president of the Michigan Allergy Society; co-chairman of the Dermatology Committee of the American College of Allergists and a fellow of the American Academy of Allergy. He is an adjunct assistant professor of medicine at Wayne State University.

The late A. A. Claytor, M.D., Saginaw,
has been honored posthumously with selection to the Saginaw Hall of Fame, the second physician to be so honored. Doctor Claytor is a former MSMS Physician of the Year and gave distinguished service in the Saginaw Housing Commission, Community Service, Red Cross and United Fund.

R. D. Mudd, M.D., Saginaw,
is new vice president of the Michigan Association for Community Health Service.

Robert L. Vitu, M.D., Saginaw,
is new speaker of the Congress of Delegates of the Michigan Academy of General Practice.

William H. Blodgett, M.D.,
an assistant professor of orthopedic surgery at Wayne State University, became president Oct. 1 of the Central United States Clinical Orthopedic Society, Inc., an affiliate of the American Academy of Orthopedic Surgery. Doctor Blodgett is chairman of the MSMS Liaison Committee with Podiatry and is chief of the Orthopaedic Section of Grace Hospital, Detroit.

Frederick C. Swartz, M.D., Lansing,
has been invited to serve on the Employment and Retirement Technical Committee of the White House Conference on Aging. Doctor Swartz was nominated to serve by the AMA.

Detroit Dermatological Society Officers

Donald J. Birmingham, M.D., Detroit, is new president of the Detroit Dermatological Society. Other new officers, all Detroit-area physicians, are William B. Taylor, M.D., president-elect; Harold Plotnick, secretary-treasurer; and Neldagae Chisa, M.D., recorder.

Mead Johnson—pharmaceuticals created for your specialized clinical needs

new solution...
to help your patients open mucus-clogged airways

new 10% solution...

particularly convenient for home use

MUCOMYST®-10

(ACETYLCYSTEINE)

liquefies thick, viscid mucus in chronic bronchitis and emphysema

Mucomyst, as 20% acetylcysteine, has been used with safety and effectiveness in hospitals for over five years.

Now a new 10% solution, Mucomyst-10, offers you the choice of prescribing a lesser concentration whenever you feel this is desirable. It provides added convenience and simplicity, particularly for your patients using nebulizing units at home.

By including Mucomyst-10 in the home management regimen, you can provide full mucolytic benefits for many of your patients with chronic bronchitis and emphysema complicated by tenacious secretions.

Indications: Mucomyst has been demonstrated to be clinically effective as adjuvant therapy in a wide range of conditions in which thick, viscous mucus is a problem, including: postoperative atelectasis and pneumonia; chronic bronchopulmonary disease (emphysema, chronic bronchitis, asthma, and bronchiectasis); acute bronchopulmonary disease (pneumonia, bronchitis, and tracheobronchitis); tracheostomy care; facilitation of bronchial studies; maintenance of an open airway during anesthesia; and to help control pulmonary complications of cystic fibrosis. **Contraindications:** Mucomyst is contraindicated in those patients who are sensitive or who have developed a sensitivity to it. **Warnings: After proper administration of acetylcysteine, an increased volume of liquefied bronchial secretions may occur. When cough is inadequate, the open airway must be maintained by mechanical suction if necessary. When there is a large mechanical block due to foreign body or local accumulation, the airway should be cleared by endotracheal aspiration, with or without bronchoscopy. Asthmatics under treatment with Mucomyst should be watched carefully. If bronchospasm progresses, this medication should be immediately discontinued. Adverse Effects:** Adverse effects have included stomatitis, nausea and rhinorrhea. Sensitivity and sensitization to Mucomyst have been reported very rarely. A few susceptible patients, particularly asthmatics (see **Warnings**), may experience varying degrees of bronchospasm associated with the administration of nebulized acetylcysteine. Most patients with bronchospasm are quickly relieved by the use of a bronchodilator given by nebulization. **Administration & Dosage:** Mucomyst may be administered by nebulization into a tent, Croupette, face mask, or mouthpiece; or by direct instillation. **Mucomyst should not be placed directly into the chamber of a heated (hot-pot) nebulizer.** Complete details on dosage, administration, and compatibility are included in the package insert. Additional information may be obtained from Mead Johnson Laboratories. **Supplied: Mucomyst-10 (acetylcysteine)**, a sterile 10% solution, in vials of 10 ml. and 30 ml.; **Mucomyst (acetylcysteine)**, a sterile 20% solution, in vials of 10 ml. and 30 ml.

MeadJohnson
LABORATORIES

9 MEAD JOHNSON & COMPANY • EVANSVILLE, INDIANA 47721 70469

Your South Pacific Adventure awaits you.

We leave on March 11, 1971 from Detroit

Join us for two sun-filled weeks in the South Pacific lands of New Zealand, Australia and Tahiti.

The cost? Just $998 complete.

Our trip to the lands "Down Under" includes Pan Am jet flights, first class hotels, two meals a day plus a host of many extras to make your adventure unforgettable!

NEW ZEALAND—Auckland's lavish gardens . . . the volcanic geysers of Rotorua . . . Waitemata Harbor and the Tasman Sea . . . the friendly Maoris and their fascinating villages.

AUSTRALIA—Sophisticated Sydney . . . the magnificent new opera house . . . the harbor bridge . . . koala bears, kangaroos . . . rugged mountains and superb surfing beaches.

TAHITI—Exotic Papeete . . . lush tropical paradise . . . gentle, life-loving Tahitians . . . white sand beaches and crystal waters.

Space on our South Pacific Adventure is strictly limited. To confirm your reservation, return the coupon today.

SEND TO: **Michigan State Medical Society**
120 West Saginaw
P.O. Box 950
East Lansing, Michigan 48823

Enclosed is my check for $_______
($100 per person as deposit)

NAME______________________________

ADDRESS___________________________

CITY_______________________________

STATE_____________________________

ZIP_____________PHONE_______________

A once-popular treatment for back pains was to have the seventh son of a seventh son stand or walk on the patient's back.

The pain of earache was allegedly relieved by holding a hot roasted onion to the ear.

For headache, a sovereign remedy was to wear a snakeskin round one's head.

A realistic approach to pain relief

'Empirin'®

Compound with Codeine Phosphate gr. 1/2 No. 3

Each tablet contains:
Codeine Phosphate gr. 1/2 (Warning—May be habit forming), Phenacetin gr. 2 1/2, Aspirin gr. 3 1/2, Caffeine gr. 1/2.

keeps the promise of pain relief

B.W. & Co.' narcotic products are Class "B", and as such are available on oral prescription, where State law permits.

BURROUGHS WELLCOME & CO. (U.S.A.) INC.
Tuckahoe, N.Y.

The actions of the official Tincture and Extract of Belladonna result chiefly from their Atropine content . . . conclude Goodman and Gilman

THE PHARMACOLOGICAL BASIS OF THERAPEUTICS
3rd Edition, page 522

ANTROCOL®

Antrocol provides the prompt, predictable antisecretory action of the belladonna alkaloid, atropine, fortified with sedation and blended with Bensulfoid, contributing to even absorption.

Each tablet or capsule contains: Atropine sulfate, 0.324 mg.; Phenobarbital, 16 mg. (may be habit forming); Bensulfoid, 65 mg. (see white section PDR). The atropine content of Antrocol is the maximum amount the average patient can take at six hour intervals over long periods with comfort.

SUPPLIED
Tablet in bottles of
100, 500 and 5000
Capsule in bottles
of 100, 500 and 1000

Caution: Federal law prohibits dispensing without prescription.

PRESCRIBING INFORMATION

Contraindicated in glaucoma. Use cautiously in prostatic hypertrophy. Side-effects of toxic dose of atropine: flushing, dryness of mouth, cycloplegia, tachycardia and urinary retention.

DOSAGE: One tablet or capsule after each meal to correct emotional stress and normalize gastric secretions. In treating peptic ulcer, doses at regular intervals up to eight (8) tablets or capsules per day to provide the proper gastric titer for healing. After ulcer has healed, one tablet or capsule after each meal to maintain a titer unfavorable to recurrence.

Clinical supply available to physicians.

WILLIAM P. POYTHRESS & CO., INC.
RICHMOND, VIRGINIA 23217
Manufacturers of Ethical Pharmaceuticals

medical care
programs

Can a Quasi-Public Corporation Control Michigan Health Care Programs?

By Herbert Mehler, Staff Assistant
MSMS Committee on
Governmental-Medical Care Programs

MSMS has secured a copy of "Medical and Health Care in Michigan: A Study of the Voluntary Payments and Delivery Systems and the Structure of Regulation."

The document was prepared for the Michigan Insurance Bureau by Macro Systems, Inc., a New York management consulting firm. The comprehensive matters discussed in this 136-plus page document are an attempt to achieve a comprehensive approach to the management and control of health care resources through joint public-private cooperation if the recommendations are adopted.

Named by the Governor to review, analyze and recommend a course of action were: Public Health Director Maurice Reizen, M.D.; Mental Health Director E. G. Yudashkin, M.D.; Social Services Director Bernard Houston; Licensing and Regulation Director Charles Harmon; Acting Director of Comprehensive State Health Planning Elena Padilla, Ph.D.; and State Insurance Commissioner Russell Van Hooser. Doctor John Dempsey, special assistant to the Governor, will be Chairman.

This highly important document will be intensively studied by appropriate MSMS officers, committees and staff. Executive and Legislative activity will be reported in future issues.

The Study had Five Principle Objectives:

1. Evaluate the operating effectiveness of Michigan Blue Cross and Michigan Blue Shield.
2. Evaluate the effectiveness of the State's jurisdiction and authority over third-party health insurance organizations.
3. Determine actions which Blue Cross/Blue Shield should take to improve the efficiency and effectiveness of its operation.
4. Develop recommendations which will improve the State's role in supervising and regulating third-party health insurance organizations.
5. Develop a plan of action for the Insurance Bureau.

The document is a summary of the consultants' report outlined as follows:

Chapter I — A description of the organization and economics of health care system in Michigan.

Chapter II — An evaluation of the controls over cost, quality, and utilization of health care exercised by the major components of the health care system.

Chapter III — An analysis of possible improvements which could be made in the present system of health care financing and control.

Chapter IV — Recommendations and alternative approaches to improving the organization and management of health care.

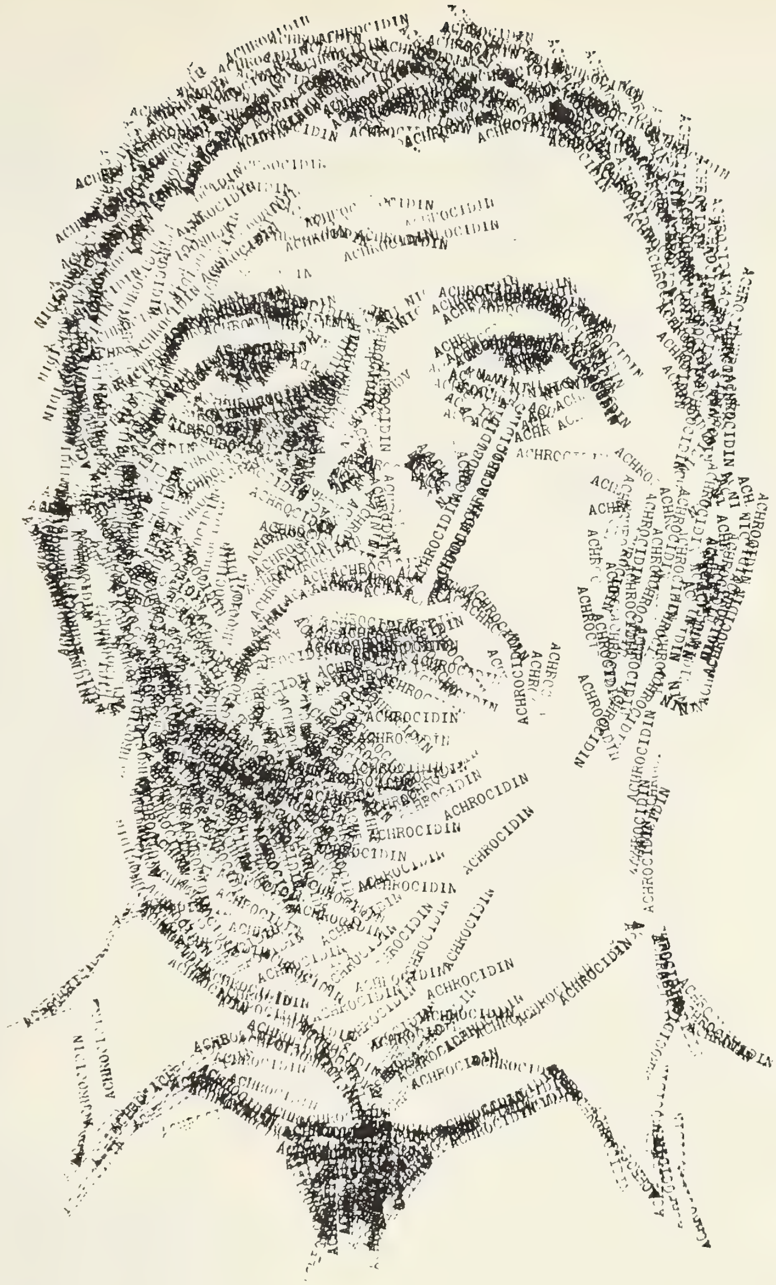
Chapter IV contains recommendations and alternative approaches to improving the organization and management of health care. Primary and secondary recommendations are:

1. *Effective planning, franchising, and institutional rate setting are the missing critical elements necessary to achieve cost and use control.*
   (a) Enact strong franchising legislation as a control mechanism for institutional conformance to comprehensive State health planning and area-wide planning decisions.
   (b) Review and approve health care institution operating and capital budgets as a basis for setting per diem rates for institutional reimbursement.
   (c) Centralize planning authority, responsibility, and coordination functions over all State and area-wide planning agencies and initiate a total State Health Plan.
   (d) Develop utilization standards for more effective use of utilization committees and require and provide information system support for institutional use as a prerequisite for reimbursement.

2. *Expanded licensing and certification functions will be needed to enforce planning decisions and to insure that on-going activities of institutions, physicians, and third-party financers are in conformance with established standards of costs, quality and use control.*
   - (a) Develop standards and expand institutional licensing and certification requirements.
   - (b) Expand licensing categories and develop standards, criteria of performance, and penalties for violations of standards for health care professionals.
3. *Changes in the functions of third-party health insurers and the laws under which they operate will be required to enable them to undertake greater responsibility for cost and use control and preserve competition.*
   - (a) Amend Public Acts 108 and 109 to permit restructuring of the Boards of Blue Shield and Blue Cross and to remove any restrictions that would prohibit a future merger of the organizations.
   - (b) Designate an agency to perform management auditing, budget review, and rate setting for institutions in accordance with specific guidelines.
   - (c) Increase existing staff of the Insurance Bureau.
   - (d) Expand the number and role of the Regional Medical Advisory Committees and ensure the protection of doctors' liability in after-the-fact peer review decisions.
   - (e) Develop and implement highly focused Blue Cross and Blue Shield consumer education programs concerned with cost of care, proper utilization, and choices of care available.
   - (f) Determine the feasibility of and benefits from merging Blue Cross and Blue Shield.
   - (g) Study the possibilities of low cost group malpractice insurance to Blue Shield full-time participating physicians as an incentive for increasing participation.
   - (h) Investigate the potential of offering dual option medical service coverage to MHS subscribers.
4. *Expand health care research and development activities at the State level.*
5. *Three principal alternatives exist for the organization and management of the health planning and control functions.*
   - (a) Strengthen existing authorities and expand the responsibilities of existing State and private agencies to ensure better planning and regulation of health services.
   - (b) Establish or designate a single organization (existing State agency, state commission, quasi-public corporation) to assume overall responsibility for health services planning, and develop management control guidelines to be further developed and implemented by designated agencies (i.e., budget review, areawide planning, franchising, utilizations standards, reimbursement basis, etc.)
   - (c) Centralize all health care planning and operating control responsibilities within a single organization (State agency or public organization).
6. *It is recommended that a quasi-public corporation be established in Michigan to perform the functions described in alternative (b).*
   - (a) Enabling legislation of the corporation must specify the composition, term of office, and minimum operating responsibilities of the Board of Directors.
   - (b) Membership of the corporation could be limited to the Directors.
   - (c) Nominating committees representing the major components of the health care system would prepare lists of candidates for Directors.
   - (d) The President of the Corporation would be appointed by the Governor.
   - (e) The Corporation could be organized into six operating departments corresponding to the Board committee structure.
   - (f) Financial control is assured through the appropriation and audit process in the use of government funds.
7. *The creation of a health care management corporation would again demonstrate Michigan's leadership in pioneering new approaches to health care planning and delivery.*
   - (a) No State has attempted to take a fully integrated management approach to the control of cost and use of health care.
   - (b) Michigan would experience little difficulty in conforming to future federal standards accompanying a more comprehensive national medical care program if the proposed concept were adopted.

Paul Piellusch Named Blue Shield Executive

Paul E. Piellusch has been named vice president of finance at Michigan Blue Shield. He previously served as an executive in service and diversified manufacturing companies, most recently National Manufacturing Co., Warren. Piellusch holds a bachelor of business administration degree from City College of New York and a master of business degree in executive management from St. John's University.



Achrocidin® Tablets and Syrup

etracycline HCl–Antihistamine–Analgesic Compound

ach tablet contains: ACHROMYCIN® Tetracycline HCl 125 mg.; Phenacetin 120 mg.; Caffeine 30 mg.; Salicylamide 150 mg.; Chlorothen Citrate 25 mg.

CHROCIDIN Tetracycline HCl–Antihistamine–Analgesic Compound Tablets and Syrup are recommended for the treatment f tetracycline-sensitive bacterial infection which may complicate vasomotor rhinitis, sinusitis and other allergic diseases of the pper respiratory tract, and for the concomitant symptomatic relief of headache and nasal congestion. For children and elderly atients you may prefer caffeine-free ACHROCIDIN Syrup. Each 5 cc contains: ACHROMYCIN Tetracycline equivalent to etracycline HCl 125 mg.; Phenacetin 120 mg.; Salicylamide 150 mg.; Ascorbic Acid (C) 25 mg.; Pyrilamine Maleate 15 mg.

ontraindications: Hypersensitivity to any omponent.
arning: In renal impairment, since liver toxcity is possible, lower doses are indicated; durng prolonged therapy consider serum level eterminations. Photodynamic reaction to sunight may occur in hypersensitive persons. hotosensitive individuals should avoid expoure; discontinue treatment if skin discomfort ccurs.
recautions: Drowsiness, anorexia, slight gasric distress can occur. In excessive drowsiess, consider longer dosage intervals. Persons on full dosage should not operate vehicles. Nonsusceptible organisms may overgrow; treat superinfection appropriately. Treat beta-hemolytic streptococcal infections at least 10 days to help prevent rheumatic fever or acute glomerulonephritis. Tetracycline may form a stable calcium complex in bone-forming tissue and may cause dental staining during tooth development (last half of pregnancy, neonatal period, infancy, early childhood).
Adverse Reactions: *Gastrointestinal*—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. *Skin*—maculopapular and erythematous rashes; exfoliative dermatitis; photosensitivity; onycholysis, nail discoloration. *Kidney*—dose-related rise in BUN. *Hypersensitivity reactions*—urticaria, angioneurotic edema, anaphylaxis. *Intracranial*—bulging fontanels in young infants. *Teeth*—yellow-brown staining; enamel hypoplasia. *Blood*—anemia, thrombocytopenic purpura, neutropenia, eosinophilia. *Liver*—cholestasis at high dosage.
Upon adverse reaction, stop medication and treat appropriately.

Lederle LEDERLE LABORATORIES, A Division of American Cyanamid Company, Pearl River, New York 10965

535-9

Menrium® treats the menopausal symptoms that bother him most.

Roche
LABORATORIES
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

His wife has a lot of different
nenopausal symptoms, but only a few
eally irritate *him*. Her hot flashes, her
ertigo, her palpitations—that's *her*
roblem. What really bothers him is
ıer nervousness, her irritability and
ıer excessive anxiety, often expressed
y endless "book-shuffling, chain-
moking, reading-lamp" insomnia!

Menrium takes care of hot flashes,
ertigo, palpitations in most
nenopausal women. Menrium
rovides the well-known antianxiety
ction of chlordiazepoxide (Librium®)
nd water-soluble esterified estrogens.
t therefore relieves more symptoms
han either component separately.
t takes care of the vasomotor
ymptoms as well as the emotional
ymptoms. This means the symptoms
hat bother his wife most. And the
ymptoms that irritate him most.

So, to help them both get through
er menopause, remember Menrium.

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Management of manifestations generally associated with the menopausal syndrome—anxiety and tension, vasomotor complaints and hormonal deficiency states.

Contraindications: Women with cancer of breast or genitalia, except inoperable cases, and those with known hypersensitivity to chlordiazepoxide and/or esterified estrogens.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Exclude other possible causes of menopausal syndrome manifestations, such as pregnancy. Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions) similar to those seen with barbiturates have been reported following discontinuance of chlordiazepoxide HCl. Potential benefits of use in pregnancy, lactation or women of childbearing age should be weighed against possible hazards to mother and child. Clinical data inadequate on safety in pregnancy.

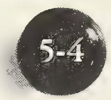
Precautions: In elderly and debilitated patients, limit dosage to smallest effective amount of chlordiazepoxide (initially 10 mg or less per day) to preclude ataxia or oversedation; increase gradually as needed and tolerated. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects—particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in patients with impaired renal or hepatic function. Paradoxical reactions to chlordiazepoxide (*e.g.*, excitement, stimulation and acute rage) have been reported in psychiatric patients. Employ usual precautions in the treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation very rarely reported in patients receiving Librium® (chlordiazepoxide) and oral anticoagulants.

Adverse Reactions: Untoward effects seen with either compound alone may occur with Menrium. With chlordiazepoxide, drowsiness, ataxia and confusion reported in some patients, particularly in the elderly and debilitated; while usually avoided by proper dosage adjustment, these are occasionally observed at lower dosage ranges. Also reported have been a few instances of syncope; isolated occurrences of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido, and occasional reports of blood dyscrasias, including agranulocytosis, jaundice and hepatic dysfunction. Periodic blood counts and liver function tests advisable during protracted treatment. Changes in EEG patterns (low-voltage fast activity) observed during and after chlordiazepoxide treatment.

With estrogens, headache, nausea and vomiting, anorexia, gastrointestinal discomfort, dysuria and urinary frequency, jitteriness, breast engorgement, formation of breast cysts, skin rashes and pruritus occasionally seen. Administration may also be associated with uterine bleeding and/or followed by withdrawal bleeding.

Usual Dosage: One tablet t.i.d. for 21 days, followed by one-week rest periods.

Menrium® T.I.D.

5 mg chlordiazepoxide		**0.2 mg water-soluble esterified estrogens**
5 mg chlordiazepoxide		**0.4 mg water-soluble esterified estrogens**
10 mg chlordiazepoxide		**0.4 mg water-soluble esterified estrogens**

county societies

Kalamazoo Physicians Have Several Projects

Members of the Kalamazoo Academy of Medicine are involved in a variety of activities. On Sept. 15, they heard Mr. Harold Green, local investment counselor, discuss the current investment outlook. Throughout this month, the physicians, their wives and children will participate in the Woman's Auxiliary annual art show at the Civic Theatre. The Academy has also reported a net of $4,600 raised during the annual Project Hope May Tag Day Sale, co-sponsored with the Kalamazoo, South and Portage Rotary Clubs, Kalamazoo Valley Dental Association, Southwest Michigan Pharmacists' Association and medical assistants.

Berrien Auxiliary Orders Film on Drugs

The Woman's Auxiliary to the Berrien County Medical Society has purchased the film, "Speedscene: The Problem of Amphetamine Abuse." The Auxiliary members will place the film in the library of the Berrien County Intermediate School District.

Kent Doctors Buy Emergency Treatment Materials

Slides and printed material in the amount of $125 have been purchased by the Kent County Medical Society to be used by the society's Committee of Emergency Medical Services. The committee maintains a training program for personnel of the police and fire departments. The materials will also be made available to the emergency room committee and director of medical education of each local hospital.

First Combined Meeting Includes Bay MDs

Dick "Night Train" Lane of the Detroit Lions was a guest at the first joint meeting Oct. 20 of the Bay County Medical Society and area lawyers, dentists and osteopaths. The combined group met at the Bay City Country Club.

Lenawee Doctors Cooperating For Safe Drug Use

A recent article in the Lenawee County Medical Society *News* describes the efforts by local pharmacists to aid Lenawee physicians in insuring the safe usage of prescription and proprietary drugs. Most Lenawee pharmacists are keeping "Family Medicine History Cards," recording all drugs sold to members of a family.

A pilot program at Bixby Hospital, Adrian, has the two hospital pharmacists interviewing patients to obtain factual drug history, investigating and identifying each drug, and placing information on the patients' charts. The Bixby Hospital pharmacists also provide automatic drug interaction notification to doctor and nurse when the patient happens to be placed on two drugs that have complex interactions that could prove hazardous.

Four New Members Added to Branch Society

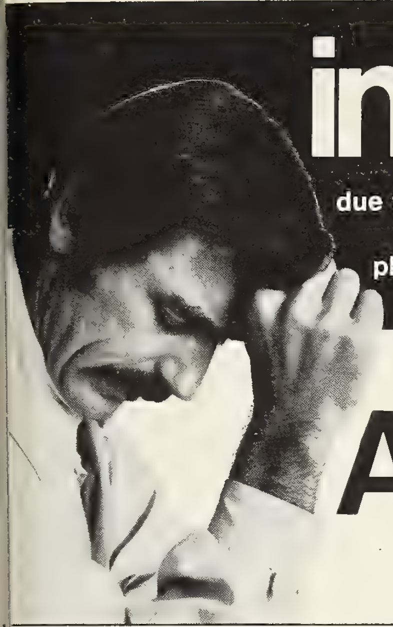
Branch County physicians point with pride at the four new members of their medical society, a substantial gain in their current enrollment of about 20 active members. County medical society members attracted the new recruits with "a real sales pitch," extolling the virtues of small town life and good facilities close to the doctor's home, according to Harvey L. Moss, M.D., Coldwater, BCMS president. The new physicians, all associated with the Community Health Center of Branch County, include a pathologist, urologist, pediatrician and internist.

All-Day Rehab Clinic Includes Gogebic MDs

Doctors of the Gogebic County Medical Society were invited to an all-day workshop on rehabilitation at the Gogebic Medical Care Facility Oct. 6. Speakers included Joseph N. Schaefer, M.D., director of the Detroit Rehabilitation Institute, and Miss Helen Millen, R.N., a consultant with the Kenny-Michigan Rehabilitation Foundation. Doctor Schaefer then met in the evening with the local physicians for further discussion.

Doctor Bornemeier To Address Kent Doctors

Walter C. Bornemeier, M.D., president of the American Medical Association, will be honored guest and speaker at the Nov. 10 meeting of the Kent County Medical Society. Doctor Bornemeier, a Chicago surgeon and past speaker of the AMA House of Delegates, was installed at the June AMA convention.



The treatment of
impotence
due to androgenic deficiency in the American male.
The concept of chemotherapy plus the physician's psychological support is confirmed as effective therapy.

NEW CLINICAL STUDY

The Treatment of Impotence
with Methyltestosterone Thyroid
(100 patients — Double Blind Study)
T. Jakobovits
Fertility and Sterility, January 1970
Official Journal of the
American Fertility Society

Android®
(thyroid-androgen) tablets

Double-Blind Study and Type of Patient:
100 patients suffering from impotence. Of the patients receiving the active medication (Android) a favourable response was seen in 78%. This compares with 40% on placebo. Although psychotherapy is indicated in patients suffering from functional impotence the concomitant role of chemotherapy (Android) cannot be disputed.

hoice of 4 strengths:

Android

ach yellow tablet contains:
ethyl Testosterone ..2.5 mg.
hyroid Ext. (1/6 gr.) ..10 mg.
lutamic Acid ....50 mg.
hiamine HCL ....10 mg.
ose: 1 tablet 3 times daily.
vailable:
ottles of 100, 500, 1000.

REFER TO PDR

Android-HP
HIGH POTENCY

Each red tablet contains:
Methyl Testosterone ..5.0 mg.
Thyroid Ext. (½ gr.) ...30 mg.
Glutamic Acid ....50 mg.
Thiamine HCL ....10 mg.
Dose: 1 tablet 3 times daily.
Available:
Bottles of 100, 500, 1000.

Android-X
EXTRA HIGH POTENCY

Each orange tablet contains:
Methyl Testosterone .12.5 mg.
Thyroid Ext. (1 gr.) ....64 mg.
Glutamic Acid ....50 mg.
Thiamine HCL ....10 mg.
Dose: 1 or 2 tablets daily.
Available:
Bottles of 60, 500.

Android-Plus
WITH HIGH POTENCY
B-COMPLEX AND VITAMIN C

Each white tablet contains:
Methyl Testosterone ..2.5 mg.
Thyroid Ext. (¼ gr.) ...15 mg.
Ascorbic Acid (Vit. C) .250 mg.
Thiamine HCL ....25 mg.
Glutamic Acid ....100 mg.
Pyridoxine HCL ....5 mg.
Niacinamide ....75 mg.
Calcium Pantothenate .10 mg.
Vitamin B-12 ....2.5 mcg.
Riboflavin ....5 mg.
Dose: 2 tablets daily.
Available: Bottles of 60, 500.

Contraindications: Android is contraindicated in patients with prostatic carcinoma, severe cardiorenal disease and severe persistent hypercalcemia, coronary heart disease and hyperthyroidism. Occasional cases of jaundice with plugging biliary canaliculi have occurred with average doses of Methyl Testosterone. Thyroid is not to be used in heart disease and hypertension.

Warnings: Large dosages may cause anorexia, nausea, vomiting abdominal pain, diarrhea, headache, dizziness, lethargy, paresthesia, skin eruptions, loss of libido in males, dysuria, edema, congestive heart failure and mammary carcinoma in males.

Precautions: If hypothyroidism is accompanied by adrenal insufficiency the latter must be corrected prior to and during thyroid administration.

Adverse Reactions: Since Androgens, in general, tend to promote retention of sodium and water, patients receiving Methyl Testosterone, in particular elderly patients, should be observed for edema.

Hypercalcemia may occur, particularly in immobilized patients: use of Testosterone should be discontinued as soon as hypercalcemia is detected.

References: 1. **Montesano, P., and Evangelista, I.** Methyltestosterone-thyroid treatment of sexual impotence. Clin Med 12:69, 1966. 2. **Dublin, M. F.** Treatment of impotence with methyltestosterone-thyroid compound. West Med 5:67, 1964. 3. **Titeff, A. S.** Methyltestosterone-thyroid in treating impotence. Gen Prac 25:6, 1962. 4. **Hellman, L., Bradlow, H. L., Zumoff, B., Fukushima, D. K., and Gallagher, T. F.** Thyroid-androgen interrelations and the hypocholesteremic effect of androsterone. J Clin Endocr 19:936, 1959. 5. **Farris, E. J., and Colton, S. W.** Effects of L-thyroxine and liothyronine on spermatogenesis. J Urol 79:863, 1958. 6. **Osol, A., and Farrar, G. E.** United States Dispensatory (ed. 25). Lippincott, Philadelphia, 1955, p. 1432. 7. **Wershub, L. P.** Sexual Impotence in the Male. Thomas, Springfield, Ill., 1959, pp. 79-99.

te for literature and samples: BROWN **THE BROWN PHARMACEUTICAL CO., INC.** 2500 West 6th Street, Los Angeles, California 90057

Established 1924

MERCYWOOD HOSPITAL

4038 Jackson Road
Conducted by Sisters of Mercy
Ann Arbor, Michigan
Telephone — 313 663-8571

Mercywood MERCY

Mercywood Hospital is a private neuropsychiatric hospital licensed by the Michigan Department of Mental Health. Mercywood specializes in intensive, multi-disciplinary treatment for emotional and mental disorders.

Accredited by the Joint Commission on Accreditation of Hospitals and the National League of Nursing. A full Blue Cross participating hospital.

Certified for: Medicare and M.A.A. programs

PSYCHIATRIC STAFF

Lyle M. Allis, M.D.
Robert J. Bahra, M.D.
Dean P. Carron, M.D.
Francis M. Daignault, M.D.
Gordon C. Dieterich, M.D.
James R. Driver, M.D.
Robert L. Fransway, M.D.
Stuart M. Gould, Jr., M.D.
Leonard E. Himler, M.D.*
Sydney Joseph, M.D.
Hubert Miller, M.D.
Jacob J. Miller, M.D.
Rudolf Nobel, M.D.
Gerard M. Schmit, M.D.
Richard D. Watkins, M.D.

*1904-1967

ancillary

Detroit Doctors Plan Fund-Raising Event To Aid African Students

On Thanksgiving Eve, Nov. 25, the African Medical Education Fund, Inc., will mark its 10th anniversary. A fund-raising "Cabaret"—like evening of entertainment is planned by Detroit-area doctors who will perform a series of musical variety acts.

The AMEF, an affiliate of the National Medical Association was founded in 1960 by the Detroit Medical Society to give financial assistance to African medical students in the United States. To date it has given help to 23 students and is currently assisting eight Africans studying medicine in the U.S.

To help meet the demand for funds the AMEF has produced a souvenir book that will be distributed during the dinner, and will be given to members of the medical community and to the African Delegation at the United Nations and Washington, D.C.

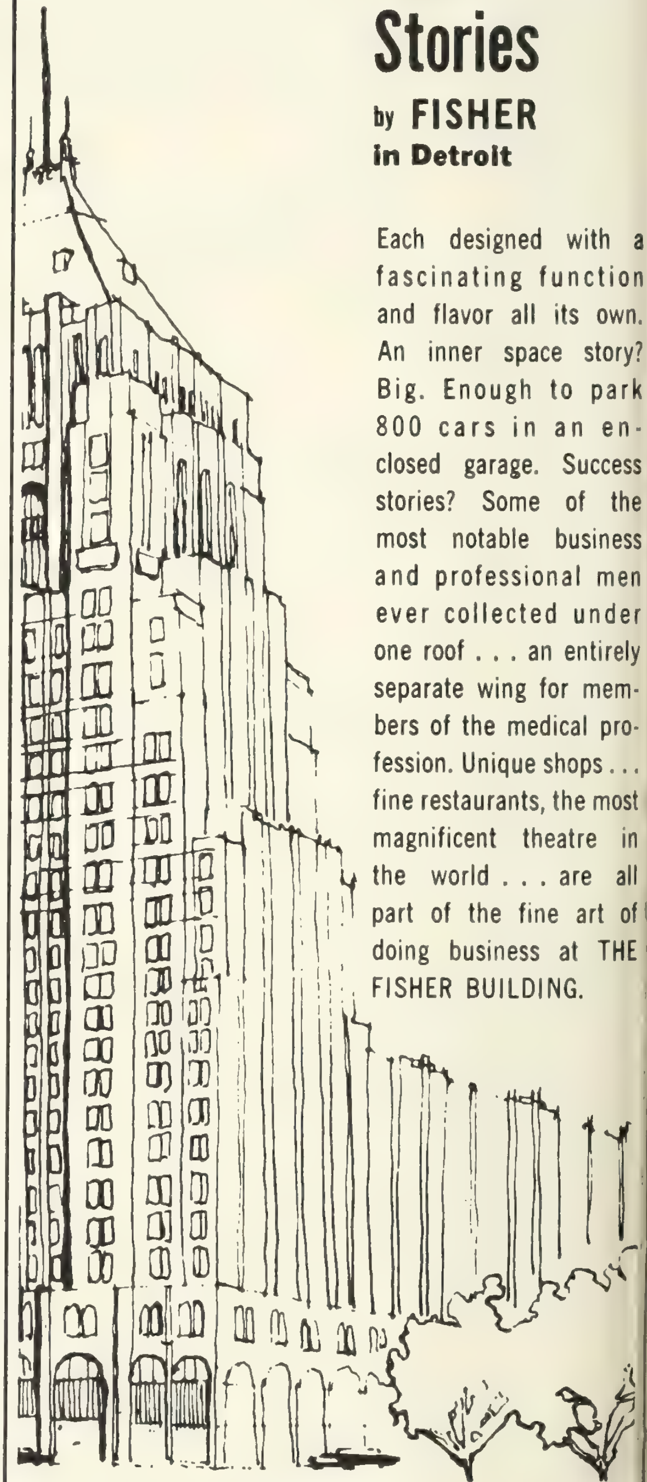
Anyone interested in contributing to the AMEF may contact Charles H. Wright, M.D., Detroit, AMEF president. Doctor Wright is also a recipient of the highest MSMS award, the Certificate of Commendation, which was presented to him several years ago.

The advertising in
MICHIGAN MEDICINE
keeps you informed
and helps pay the
publishing costs.

When the local
representative calls, Doctor,
tell him you saw
his company's ad
in your journal.

28 Tall Stories by FISHER in Detroit

Each designed with a fascinating function and flavor all its own. An inner space story? Big. Enough to park 800 cars in an enclosed garage. Success stories? Some of the most notable business and professional men ever collected under one roof . . . an entirely separate wing for members of the medical profession. Unique shops . . . fine restaurants, the most magnificent theatre in the world . . . are all part of the fine art of doing business at THE FISHER BUILDING.



Call or write the Rental Office
THE FISHER BUILDING
Across from the General Motors Bldg.
Detroit, Mich. 48202 (313)874-4444

The girth control pill

Tepanil® Ten-tab

(continuous release form)

(diethylpropion hydrochloride)

works on the appetite not on the 'nerves'

When girth gets out of control, TEPANIL can provide sound support for the weight control program you recommend. TEPANIL reduces the appetite—patients enjoy food but eat less. Weight loss is significant—gradual—yet there is a relatively low incidence of CNS stimulation.

Contraindications: Concurrently with MAO inhibitors, in patients hypersensitive to this drug; in emotionally unstable patients susceptible to drug abuse.

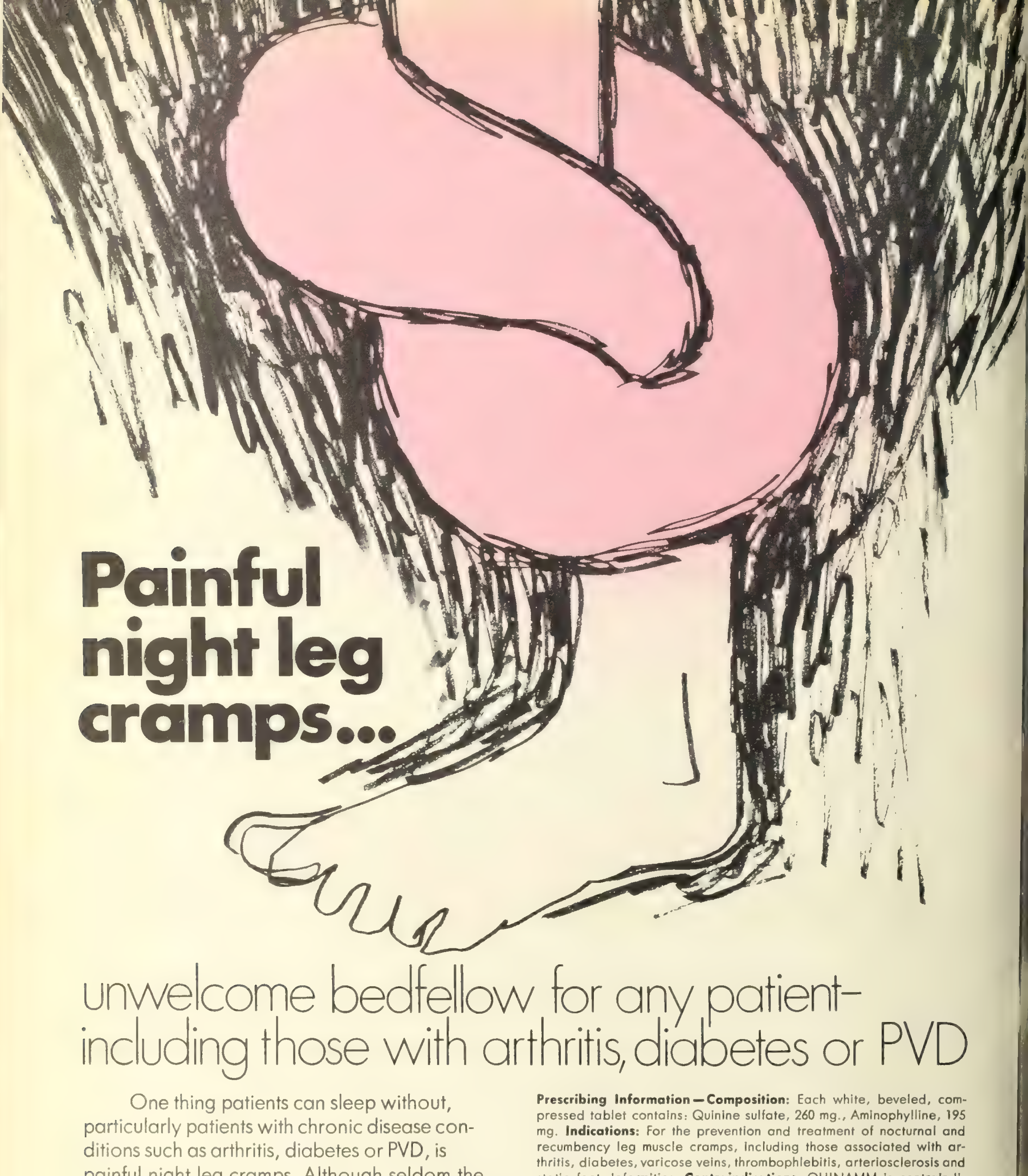
Warning: Although generally safer than the amphetamines, use with great caution in patients with severe hypertension or severe cardiovascular disease. Do not use during first trimester of pregnancy unless potential benefits outweigh potential risks.

Adverse Reactions: Rarely severe enough to require discontinuation of therapy, unpleasant symptoms with diethylpropion hydrochloride have been reported to occur in relatively low incidence. As is characteristic of sympathomimetic agents, it may occasionally cause *CNS effects* such as insomnia, nervousness, dizziness, anxiety, and jitteriness. In contrast, CNS depression has been reported. In a few epileptics an increase in convulsive episodes has been reported. Sympathomimetic *cardiovascular effects* reported include ones such as tachycardia, precordial pain, arrhythmia, palpitation, and increased blood pressure. One published report described T-wave changes in the ECG of a healthy young male after ingestion of diethylpropion hydrochloride; this was an isolated experience, which has not been reported by others. *Allergic phenomena* reported include such conditions as rash, urticaria, ecchymosis, and erythema. *Gastrointestinal effects* such as diarrhea, constipation, nausea, vomiting, and abdominal discomfort have been reported. Specific reports on the hematopoietic system include two each of bone marrow depression, agranulocytosis, and leukopenia. A variety of miscellaneous adverse reactions have been reported by physicians. These include complaints such as dry mouth, headache, dyspnea, menstrual upset, hair loss, muscle pain, decreased libido, dysuria, and polyuria.

Convenience of two dosage forms: TEPANIL Ten-tab tablets: One 75 mg. tablet daily, swallowed whole, in midmorning (10 a.m.); TEPANIL: One 25 mg. tablet three times daily, one hour before meals. If desired, an additional tablet may be given in midevening to overcome night hunger. Use in children under 12 years of age is not recommended.

T-006A / 1/70 / U.S. PATENT NO. 3,001,910

THE NATIONAL DRUG COMPANY
DIVISION OF RICHARDSON-MERRELL INC.
PHILADELPHIA, PENNSYLVANIA 19144



Painful night leg cramps...

unwelcome bedfellow for any patient—including those with arthritis, diabetes or PVD

One thing patients can sleep without, particularly patients with chronic disease conditions such as arthritis, diabetes or PVD, is painful night leg cramps. Although seldom the presenting complaint, night leg cramps can tie your patients up in painful knots. Now, just one tablet of QUINAMM at bedtime can usually bring an end to shattered sleep and needless suffering. Your patients will sleep restfully—gratefully—with QUINAMM, specific therapy to prevent painful night leg cramps.

Prescribing Information—Composition: Each white, beveled, compressed tablet contains: Quinine sulfate, 260 mg., Aminophylline, 195 mg. **Indications:** For the prevention and treatment of nocturnal and recumbency leg muscle cramps, including those associated with arthritis, diabetes, varicose veins, thrombophlebitis, arteriosclerosis and static foot deformities. **Contraindications:** QUINAMM is contraindicated in pregnancy because of its quinine content. **Precautions/Adverse Reactions:** Aminophylline may produce intestinal cramps in some instances, and quinine may produce symptoms of cinchonism, such as tinnitus, dizziness, and gastrointestinal disturbance. Discontinue use if ringing in the ears, deafness, skin rash, or visual disturbances occur. **Dosage:** One tablet upon retiring. Where necessary, dosage may be increased to one tablet following the evening meal and one tablet upon retiring. **Supplied:** Bottles of 100 and 500 tablets.

THE NATIONAL DRUG COMPANY
DIVISION OF RICHARDSON-MERRELL INC.
PHILADELPHIA, PENNSYLVANIA 19144

Quinamm™ Specific therapy for night leg cramps
(quinine sulfate 260 mg., aminophylline 195 mg.)

Pat Hudson has angina.
But he hardly ever thinks about it.

New STEPS™

PENTAERYTHRITOL TETRANITRATE

Timed Disintegration Capsules

Give him prophylaxis against angina pectoris
Convenience of twice-a-day dosage
Greater peace of mind

Each capsule is designed to provide vasodilating effect for up to 12 hours. Conventional dosage forms of pentaerythritol tetranitrate (PETN), which must be taken every 3 to 4 hours, keep some patients reminded of their disability throughout the day. And some, taking short-acting dosage forms, become quite apprehensive about being without medication while asleep.

Dosage range that now lets you control nitrite therapy.

STEPS pentaerythritol tetranitrate timed disintegration capsules not only give the patient more convenience and peace of mind, they let you prescribe the dose an individual patient needs.

STEPS comes in 3 potencies—30 mg. 50 mg. and 80 mg.—to help you determine the optimal level of effectiveness in providing relief from the frequency and intensity of anginal attacks.

The wide potency range of STEPS allows you to adjust the dosage to meet the patient's needs. Moreover, if therapy must be altered or discontinued due to nitrite tolerance, the flexible dosage of STEPS permits resumption of therapy at the smallest effective dose.

(See next page for complete dosage recommendations and precautions.)

New

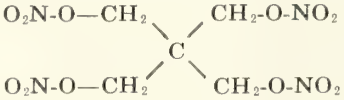
STEPS™ PENTAERYTHRITOL TETRANITRATE

Timed Disintegration Capsules

Available in three potencies for greater dosage flexibility and better control of therapy.

CAUTION: Federal law prohibits dispensing without prescription.

DESCRIPTION: Pentaerythritol Tetranitrate Structural Formula:



Empirical Formula: $C_5H_8N_4O_{12}$ Molecular Weight: 316.15. The pentaerythritol tetranitrate is in a special timed disintegration base providing for prolonged therapeutic effect.

MODE OF ACTION: The mechanism of action in the relief of angina pectoris is unknown at this time, although the basic pharmacologic action is to relax smooth muscle.

INDICATIONS: For the relief of angina pectoris (pain of coronary artery disease). It is not intended to abort the acute anginal episode, but is widely regarded as useful in the prophylactic treatment of angina pectoris.

CONTRAINDICATIONS: Idiosyncrasy to this drug.

WARNINGS: Data supporting the use of nitrites during the early days of the acute phase of myocardial infarction (the period during which clinical and laboratory findings are unstable) are insufficient to establish safety. Keep out of reach of children.

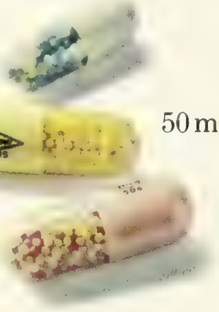
PRECAUTIONS: Intraocular pressure is increased; therefore, caution is required in administering to patients with glaucoma. Tolerance to this drug, and cross-tolerance to other nitrites and nitrates may occur.

ADVERSE REACTIONS: Cutaneous vasodilation with flushing. Headache is common and may be severe and persistent. Transient episodes of dizziness and weakness, as well as other signs of cerebral ischemia associated with postural hypotension, may occasionally develop. This drug can act as a physiological antagonist to norepinephrine, acetylcholine, histamine, and many other agents. An occasional individual exhibits marked sensitivity to the hypotensive effects of nitrite and severe responses (nausea, vomiting, weakness, restlessness, pallor, perspiration and collapse) can occur, even with the usual therapeutic dose. Alcohol may enhance this effect. Drug rash and or exfoliative dermatitis may occasionally occur.

DOSAGE AND ADMINISTRATION: One capsule every 12 hours on an empty stomach. (Not recommended for sublingual use.)

HOW SUPPLIED: STEPS pentaerythritol tetranitrate timed disintegration capsules are available in 30 mg. (NDC 183-504-2), 50 mg. (NDC 183-505-2), and 80 mg. (NDC 183-506-2) sizes. Each capsule size is packaged in bottles of 100.

STORAGE: Capsules should be stored in a cool, dry place in a light-resistant container out of the reach of children.



DOW

THE DOW CHEMICAL COMPANY
Rx Pharmaceuticals, Indianapolis

Drip stopped, Congestion cleared

For upper respiratory allergies and infections, up to 12 hours clear breathing on one tablet. Dimetapp Extentabs® do an outstanding job of helping clear up the stuffiness, drip and congestion of colds and upper respiratory allergies and infections. Each Extentab keeps working up to 12 hours. And for most patients drowsiness or overstimulation is unlikely.

INDICATIONS: Dimetapp is indicated for symptomatic relief of the allergic manifestations of respiratory illnesses, such as the common cold and bronchial asthma, seasonal allergies, rhinitis, conjunctivitis, and otitis. CONTRAINDICATIONS: Hypersensitivity to antihistamines. Not recommended for use during pregnancy. PRECAUTIONS: Until patient's response has been determined, he should be cautioned against engaging in operations requiring alertness. Administer with care to patients with cardiac or peripheral vascular diseases or hypertension. SIDE EFFECTS: Hypersensitivity reactions including skin rashes, urticaria, hypotension and thrombocytopenia, have been reported on rare occasions. Drowsiness, lassitude, nausea, giddiness, dryness of the mouth, mydriasis, increased irritability or excitement may be encountered. DOSAGE: 1 Extentab morning and evening. SUPPLIED: Bottles of 100 and 500.

A·H·ROBINS
A. H. Robins Company
Richmond, Va. 23220

Dimetapp Extentabs®

Dimetane® (brompheniramine maleate), 12 mg.; phenylephrine HCl, 15 mg.; phenylpropanolamine HCl, 15 mg.

when an unnerving experience compounds the pain

the compound analgesic that calms instead of caffeinates

In addition to pain, this patient has experienced anxiety, fear, embarrassment, and frustration. No doubt these psychic factors actually increased her perception of pain. Surely the last thing she needs is an analgesic containing caffeine. The logical choice is Phenaphen with Codeine. It provides a quarter grain of phenobarbital to take the nervous "edge" off, so the rest of the formula can control the pain more effectively. It's no accident that the Phenaphen formulations contain a sedative rather than a stimulant. Don't you agree, Doctor, that psychic overlay is an important factor in most of the accident cases you see?

Phenaphen®
with Codeine

Phenaphen with Codeine Nos. 2, 3, or 4 contains: Phenobarbital ($\frac{1}{4}$ gr.), 16.2 mg. (warning: may be habit forming); Aspirin ($2\frac{1}{2}$ gr.), 162.0 mg.; Phenacetin (3 gr.), 194.0 mg.; Hyoscyamine sulfate, 0.031 mg.; Codeine phosphate, $\frac{1}{4}$ gr. (No. 2), $\frac{1}{2}$ gr. (No. 3), or 1 gr. (No. 4) (warning: may be habit forming). **Indications:** Provides relief in severer grades of pain, on low codeine dosage, with minimal possibility of side effects. Its use frequently makes unnecessary the use of addicting narcotics. **Contraindications:** Hypersensitivity to any of the components. **Precautions:** As with all phenacetin-containing products, excessive or prolonged use should be avoided. **Side effects:** Side effects are uncommon, although nausea, constipation and drowsiness may occur. **Dosage:** Phenaphen No. 2 and No. 3—1 or 2 capsules every 3 to 4 hours as needed; Phenaphen No. 4—1 capsule every 3 to 4 hours as needed. For further details see product literature.
A. H. Robins Company, Richmond, Va.

A·H·ROBINS

in memoriam

Lawrence W. Faust, M.D.
Saranac

Lawrence W. Faust, M.D., retired Grand Rapids area urologist, died Sept. 13 at the age of 76.

Doctor Faust was former consulting and attending urologist and chief of staff at St. Mary's Hospital, Grand Rapids, and had been affiliated with Blodgett Memorial and Butterworth Hospitals there.

He was a life member of the American College of Surgeons and belonged to the Detroit Urological Society. Doctor Faust was a graduate of the University of Michigan Medical School.

Stanley C. Fenton, M.D.
Detroit

Stanley Clinton Fenton, M.D., retired Detroit physician, died Sept. 15 at the age of 75.

Doctor Fenton was a retired member of the staffs of St. John and Grace Hospitals in Detroit and was a graduate of Wayne State University School of Medicine. He was a member of the American Academy of General Practice.

Harold R. Gilbert, M.D.
Lincoln Park

Harold R. Gilbert, M.D., Wyandotte and Southgate physician for 28 years, died Sept. 4 at the age of 59.

Doctor Gilbert, a graduate of Washington University, St. Louis, Mo., was on the staff at Wyandotte General Hospital and was plant physician at Pennwalt Corporation, Riverview-Wyandotte. He was a general practitioner.

Cameron Haight, M.D.
Ann Arbor

Cameron Haight, M.D., internationally known surgeon and member of the University of Michigan medical faculty since 1931, died Sept. 25 at the age of 69.

Doctor Haight was head of the U-M Section on Thoracic Surgery and in 1931 became first physician in the United States to remove an entire lung successfully. He received the William Edwards Ladd Award from the surgical section of the American Academy of Pediatrics in 1967 for his work with infants having congenital abnormalities of the esophagus.

Doctor Haight also received the Bruce H. Douglas Award of the Michigan Thoracic Society for his contributions in the surgical treatment of pulmonary tuberculosis.

He was graduated from Harvard Medical School and was a past president of the American Association for Thoracic Surgery and a founding member and chairman of the Board of Thoracic Surgery. He was a member of the editorial board of the *Journal of Thoracic and Cardiovascular Surgery* since 1954 and of numerous other medical organizations.

Marion A. Hunter, M.D.
Monroe

Marion Arnold Hunter, M.D., Monroe general practitioner for 39 years, died Sept. 3 at the age of 72.

Doctor Hunter was a graduate of the University of Michigan Medical School and had been affiliated with Monroe Mercy Hospital. He retired in 1963. He was a past president of the Monroe County Medical Society.

Leonard D. MacRae, M.D.
Bay City

Leonard Douglas MacRae, M.D., Bay City physician who researched the use of carbon dioxide as an anesthetic and a treatment for nervous disorders, died Sept. 17 at the age of 64.

Doctor MacRae had also researched the effects and control of dicumarol dosage and collaborated in writing a textbook on carbon dioxide therapy. He specialized in diencephalology.

A graduate of the University of Michigan Medical School, Doctor MacRae was a member of the Academy of Psychosomatic Medicine and medical psychiatry specialty organizations.

William T. McAlonan, M.D.
Detroit

William T. McAlonan, M.D., former chief of the Detroit Fire Department's medical division, died Sept. 6 at the age of 79.

Doctor McAlonan was also a former surgeon for the Michigan Department of the VFW and was formerly affiliated with the American Red Cross. He was honored on May 17, 1967 on the 50th anniversary of his graduation from Wayne State University School of Medicine.

Harold A. Robinson, M.D.
Southfield

Harold Abraham Robinson, M.D., owner and medical director of the Bedford Villa Nursing Home, Southfield, died Sept. 4 at the age of 66.

Doctor Robinson was graduated from the University of Michigan Medical School and was affiliated with Lister General and Sinai Hospitals in the Detroit area. He was a fellow of the American College of Nursing Home Administrators and the American College of Physicians. He was an internist.

Charles W. Sellers, M.D.
Detroit

Charles W. Sellers, M.D., Detroit general practitioner, former editor and member of the *Detroit Medical News* editorial board for 14 years, died Sept. 10 at the age of 76.

Doctor Sellers was on the staff of Detroit's Grace Hospital during his entire medical career and served as its chief of the General Practice Division, attaining the rank of consultant.

Doctor Sellers was author of a number of books on medicine, philosophy and psychology. He was past president of the Wayne County Academy of General Practice; was former chairman of the board of the Wayne County Medical Society trustees and was secretary of the Michigan chapter of the American Medical Writers Association.

He was a graduate of the Detroit College of Medicine.

Emery D. Winfield
Grand Rapids

Emery D. Winfield, M.D., retired Grand Rapids general practitioner, died Sept. 18 at the age of 74.

Doctor Winfield was a life member of MSMS and was cited in January by the Kent County Medical Society for his devotion and service to his patients and community.

Doctor Winfield was graduated from the University of Michigan Medical School and practiced in Leslie before joining the Grand Rapids medical community in 1928. He was affiliated with Blodgett Memorial and St. Mary's Hospitals in Grand Rapids and retired in 1967.

BRIGHTON HOSPITAL

A non-profit foundation

FOR ALCOHOLISM

Member, Michigan Hospital Association, American Hospital Association

A facility designed to rehabilitate and aid the compulsive drinker in arresting his addiction.

Brighton Hospital meets the standards established by the Michigan State Board of Alcoholism and is recommended by that Board.

12851 East Grand River
One block south of I-96 at Kensington Rd. Exit
four miles east of U.S. 23
Brighton, Michigan
ACademy 7-1211

(A 16-m.m. sound color film on Brighton Hospital is available for free loan to qualified groups.)

In Germany, with all these other great cars around, the Audi is completely sold out.

One week after the Audi 100LS was introduced in Germany there was a waiting list three months long. Six months later, it was up to nine months. In fact, today, the Audi is the fastest selling car in Germany.

Why?

Simple. The Audi has features that are more advanced than just about every other car around. (61 years of engineering experience saw to that.)

There's front-wheel drive. So you can corner surer. Even on the most terrifying curve.

There's rack-and-pinion steering. Which is far and away the simplest, most direct, most responsive steering system devised by man.

There's also those inboard front disc brakes. They're right in the car's airstream to keep them cool. So you can keep cool and not worry about them fading. They're also large enough to bring an Audi moving 60 mph to a complete stop in four seconds.

And as for the engine, well, it can go from 0 to 60 in 11 seconds and still get about 26 miles to the gallon.

Why even the interior is filled with such luxurious features as seats that were designed by orthopedic surgeons. A heating and ventilation system that completely changes the air every 30 seconds. And . . . well, we could go on and on.

But one has to actually drive the Audi to know how the Audi actually drives. So why not come in and take it around the block a couple of times.

There may be a waiting list in Germany. But we don't have one here.

Yet.

The Audi®
Made in Germany

Mercedes-Benz
Porsche
Volkswagen
BMW

Porsche Audi: a division of Volkswagen of America, Inc.

Phil Gordon's, Inc.
2924 E. Grand River Ave., Lansing

Tom Sullivan Porsche Audi, Inc.
499 S. Hunter Blvd., Birmingham

Prestige Automobiles, Inc.
2955 S. Division Ave., Grand Rapids

Wood Imports, Inc.
15415 Gratiot Ave., Detroit

International Drug Symposium Nov. 9-13 at U-M

The International Drug Abuse Symposium for physicians planned Nov. 9-13 at the Rackham Building, the University of Michigan campus, will provide five days of discussions by international experts in the field.

The symposium is designed to help the practicing physician deal more effectively with the problem of drug abuse — not merely in the context of the individual physician-patient relationship, but also as a participant in community action programs with school officials, the courts and representatives of social agencies.

Twenty-four separate agencies, among them several drug companies, have given support for the meeting.

Among the speakers will be Jean Napote, secretary-general of INTERPOL, who will discuss the agency's activities in controlling dangerous drugs.

Ec-
on-
omy!

Dicarbosil®
ANTACID

Your ulcer patients and others will appreciate it. Specify DICARBOSIL 144's — 144 tablets in 12 rolls.

ARCH LABORATORIES
319 South Fourth Street, St. Louis, Missouri 63102

Specialized★ Service
IN
PROFESSIONAL LIABILITY INSURANCE
is a high mark of distinction

THE
MEDICAL PROTECTIVE COMPANY
FORT WAYNE, INDIANA

Professional Protection Exclusively since 1899

DETROIT OFFICE: R. K. Wind and J. K. Galloway, Representatives
27200 Lahser Road, Southfield 48075, Telephone: (Area Code 313) ELgin 3-4848 or 444-1439

GRAND RAPIDS OFFICE: G. J. Haworth, Representative
422 Federal Square Building, Grand Rapids 49502 Telephone: 616-454-4477

Someone acutely ill needs this bed.

It's available because of Medicenter.

Because of Medicenter, this hospital bed can be used y someone who needs it. That's what Medicenter is l about. A recuperative care facility specializing in the eeds of patients who no longer require the intensive care a general hospital and who are on the road to recovery.

But that's only part of the Medicenter story . . . Beauti- lly carpeted and draped patient rooms, tasty foods, rec- ation facilities, physical and inhalation therapy are st a few of many luxurious health care features that ake recovery in the Medicenter as pleasant and rapid as possible. The Medicenter is within minutes of acute care facilities. A professional medical staff supervises all recuperative care under the direct orders of each patient's personal physician. Room rates are nominal — about one-half the cost of general hospitals. And there's a growing list of insurance companies that already provide coverage for Medicenter recuperation.

The Medicenter is a vital addition to our community's health care system. Get to know the Medicenter soon. Your visit or inquiry is welcome anytime.

MEDiCENTER
OF AMERICA

A Nice Place to Get Well

Medicenter of America / Chelsea • Escanaba • Flint, Michigan

Classified Advertising

$5.00 per insertion of 50 words or less, with an additional 10 cents per word in excess of 50.

FAMILY PRACTICE PHYSICIANS – Board of Trustees of St. Mary's Hospital in Marquette invites family practice physicians to practice in Michigan's upper peninsula. This community has two hospitals, excellent schools, churches and year-round sports activities. This hospital is a 126 bed modern, well equipped, JCAH accredited general hospital including psychiatric and rehabilitation units in which to practice professional skills. Interested physicians may contact: Archie S. Narotzky, M.D., Chief of Staff, St. Mary's Hospital, Marquette, Michigan 49855.

ANN ARBOR–YPSILANTI AREA. 3 yr. AMA approved, university affiliated psych. residency at mental health center offering comprehensive services to SE Mich. Teaching faculty & supervisors include U. of M. faculty, private psychiatrists & analysts, as well as hospital staff. Resident's time divided approx. equally between didactic seminars (including supervision) & clinical experience. First year ADM & Intensive Treatment Units; second & third year assigned Community Psych. and/or OPC and/or Children's unit. Additional experience in psychosomatic medicine, Univ. Mental Hygiene Clinic, and neurology. 3-year: $11,358 to $12,924. 5-yr: $12,945 to $23,197. $15,000 NIMH grants & dependency allowance ($500 per) available to eligible physicians in practice 4+ years. Contact: J. Tiziani, M.D., Ypsilanti State Hospital, Ypsilanti, Michigan 48197.

General Surgeon wishes to locate in State of Michigan. Would consider any area except city of Detroit. Would consider Association or group practice in General and Industrial Surgery. Reply Box 19, 120 W. Saginaw Street, East Lansing, Michigan 48823.

Semi-retire in Florida!! Clean air, fishing and beaches. Emergency room physicians needed full time for expanding Florida Hospital. Must have Florida License and qualify for Active Staff privileges. Fee for service with Guarantee of $300 per 24 hour day. No overhead. Hospital does billing of fees at no expense to you. Write E. Gilbert Slatton, Administrator, Wuesthoff Memorial Hospital, Rockledge, Florida 32955.

WANTED: Internist to join two man partnership in Michigan's upper thumb area. Excellent recreation and educational facilities are available. Write to: K. B. Herrington, M.D. or Kenneth S. Kube, M.D., 669 South Van Dyke, Bad Axe, Michigan. May call collect: (517) 269-6453.

WANTED: General practitioner to join active group in large non-OB, non-pediatric practice with large industrial component. Well established. New building. X-Ray–Laboratory facilities–Cincinnati area. Future bonanza for right person willing to work. Reply Box 18, 120 West Saginaw Street, East Lansing, Michigan 48823.

Chief of Medical Staff – Regular hours, $30,589 annually, excellent fringe benefits. Smog free, peaceful, cultural, vacationland community. Sound Great? It's all yours if you are a boarded internist or generalist. Apply to M. Duane Sommerness, M.D., Box C, Room 246, Traverse City State Hospital, Traverse City, Michigan 49684. An equal opportunity employer.

ANESTHESIOLOGIST: Age 42, married, University trained (Canada). Experienced in all types of anesthetics including pediatrics. Would like to relocate in Wayne, Genesee, Oakland, Washtenaw or Ingham counties. Will consider other replies. Reply Box 17, 120 W. Saginaw Street, East Lansing, Mi 48823.

NEW EXPANDING OPPORTUNITIES for family physicians and physicians specializing in pediatrics, internal medicine, urology, anesthesiology; in medically-awakening community. Contemporary, automated, 105-bed, new hospital to be completed in the fall of 1970. Present hospital to be converted into long-term unit. Patient service area 50,000 people. Medical staff leading and supporting recruitment efforts. Excellent community location, forty miles equidistant to Milwaukee or Madison. Complete educational, cultural and recreational facilities. A new medical – dental building and a 130-bed skilled care nursing home being constructed adjacent to the new hospital ready for occupancy January 1971. Immediate satisfaction in practice, income and family living. Special assistance if needed. Write or call Paul R. Glunz, M.D., Watertown Memorial Hospital, 1301 E. Main Street, Watertown, Wisconsin 53094; Telephone (414) 261-4210 for more information.

VACATION ON FLORIDA'S GOLD COAST: 2 bedroom T-bird villa in Coral Springs. Quiet and private. 18 hole golf course, tennis, swimming pool on premises. Available year-round on monthly or weekly rental basis. Rest and recuperate that weary mind and body. Contact Dr. J. Heidenreich, Marshall, Michigan (616) 781-7997.

A GENERALIST OR INTERNIST for admitting Outpatient Clinic. 40 hour week. 30 day leave. With excellent fringe benefits in beautiful University City with many cultural advantages. Salary range $22,000 to $29,000, depending upon experience and training. Write or call Chief of Staff, VA Hospital, Ann Arbor, Michigan. Telephone (313) 769-7100, Ext. 331.

GENERAL PRACTITIONER: For pension examinations and Admitting Officer assignment. 233-bed hospital in small Michigan community offering ideal family living, a superior school system, and all seasons sports vacation-land. Full staff of highly qualified physicians; 80% of whom are Board Certified. Licensure any state. U. S. citizenship. Salary based on qualifications. Excellent fringe benefits. Non-discrimination in employment. Contact: Chief of Staff, VA Hospital, Iron Mountain, Michigan 49801.

Increase Practice Control Through MANAGEMENT By

OBJECTIVES

Modern office and financial management offers realistic methods toward achievement of personal life goals. A logical outcome of PM's services is the attainment of your objectives.

- More Time for Patient
- More Time for Leisure
- Better Collection Control
- Better Cost Control
- Assistance With Financial Planning
- Identify Business Problems
- Seek Best Solutions to Problems

PROFESSIONAL MANAGEMENT · PM · FOR PHYSICIANS AND DENTISTS · *since 1932*

PROFESSIONAL MANAGEMENT

Black and Skaggs Associates, Inc.
Battle Creek, Michigan

Serving Michigan Physicians

Offices in these cities
Ann Arbor - Battle Creek - Berkley - Detroit - Flint
Grand Rapids - Lansing - Muskegon - Saginaw - Traverse City

BOARD CERTIFIED PSYCHIATRIST. Average daily census—1204; predominately psychiatric VA hospital, located in East Central Indiana. Special programs in psychiatric and geriatric rehabilitation; alcoholic treatment unit. Active medical service. Family rental units at reasonable rates usually available on hospital grounds. 30 days leave annually; retirement; health, life insurance plans without physical examination; and other benefits. Will pay moving expenses. Salary $19,643-$29,752 depending on qualifications. License any state required. Equal opportunity employer. Contact Chief of Staff, VA Hospital, Marion, Indiana 46952 or call Area 317, 674-3321.

WANTED: Locum tenens in Southwestern Michigan for two weeks at the end of December 1970. I am a surgical resident and have a Michigan license. Reply to 504 Sixth Avenue, Coralville, Iowa 52240.

WANTED: Partner-Associate for busy family practice in N.W. Detroit suburb. No OB. Rapidly expanding area with nearby hospital expansion underway. Terms open. Reply: Box 22, 120 W. Saginaw St., East Lansing, Michigan 48823.

Internist, OB-GYN, Radiologist, and Urologist needed for additional staff to established 15 man medical group in Detroit. Excellent financial opportunities and fringe benefits. Box 20, 120 West Saginaw Street, East Lansing, Michigan 48823.

Index to Advertisers

Arch Laboratories 1042
Breon Laboratories 975
Brighton Hospital 1040
Brown Pharmaceuticals 1029
Burroughs-Wellcome & Co. 1021
Campbell Soup Co. 1003
Classified Ads 1044, 1045
Dow Chemical Co. 1033, 1034, 1035, 1036
Fisher Bldg. 1030
Hynson, Westcott and Dunning, Inc. 971
Import Motors 1041
Lederle Laboratories 972, 1025
Lilly, Eli and Co. 980
Loma-Linda Foods 1009
Mead Johnson Laboratories 1018, 1019
Medical Protective Co. 1042
Medicenter of America 1043
Mercywood Hospital 1029
Michigan State Medical Society 1020
National Drug Co. 1007, 1008, 1031, 1032
Poythress, Wm. P. 1022
Professional Management 1045
Professional Service Corp. . . . . Cover II
Robins, A.H. 1012, 1013, 1037, 1038
Roche Laboratories 1014, 1015, 1016,
1026, 1027, Cover IV
1026, 1027, Cover IV
Searle, G. D., and Co. 1004, 1005
Stratton, Ben P., Ins. . . . . Cover III
Stuart 1006
Walker Corp. and Co. 1010, 1011

noted and quoted

BY HERB AUER, EXECUTIVE EDITOR

The following thoughts about drug abuse were written by Edward W. Cannady, M.D., president of the Illinois State Medical Society, in the *Illinois Medical Journal*:

"Thousands of our young people are being kidnapped each year, while parents and community stand by helplessly. The kidnapper is drug abuse, and our children and teenagers are unwittingly following it on dead-end 'trips' to nowhere.

"As parents ourselves, we share the concern of all parents about the drug abuse. And as physicians, we hold a special responsibility to help the community rid itself of this menace . . ."

* * *

The Detroit News reply to a letter in its Contact 10 feature tended to keep some issues in perspective the other day. A lady wrote in to ask why medical students "are allowed to wear beards, mustaches and wild hair styles?"

Contact 10 printed photos of Doctors Louis Pasteur and Albert Schweitzer complete with their mustaches, etc. The **News** suggested further that, "Other hirsute healers that you wouldn't like would include Hippocrates, Sir Joseph Lister and many others."

* * *

Missouri State Medical Association President Joseph L. Fisher, M.D., recently ended a journal article:

"Our collective heads are stuck in the sand if we do not recognize (1) the importance of AMA membership, (2) the importance of AMPAC and state PACs, (3) upcoming political events, (4) medical legislation and (5) our individual responsibilities in these areas."

* * *

Saw a recent comment from the AMA that not many physicians know . . . If the AMA had no income from outside sources the AMA dues would have to be $188 to support the present AMA programs. The AMA official pointed out, "that each of our AMA members is receiving $188 worth of service for $70." Advertising in *JAMA* is the major source of outside income.

* * *

Recently a medical journal carried an item with this statement:

> *"There are now eight patients with kidneys from cadaver donors alive for more than one year."*

Two members of the Cleveland Clinic Foundation collect such maladies that sneak into medical journals. Stanley O. Hoerr, M.D., and Mildred Hoerr Lysle, S.M., wrote an article, "Treatment of Maladies in Medical Writing" in the *American Medical Writers Association Bulletin* and shared some of the errors they spotted.

The authors report that the "most obvious errors include the misspelling of the names of syndromes, positions and signs; incorrect punctuation; and inaccurate citation of references."

* * *

A newspaper article recently reported that one of the major manufacturers of glue is seriously considering adding a horseradish scent to its glue to help combat glue-sniffing among teen-agers. The firm believes the horseradish scent would cause so much sneezing that it would prevent or reduce damaging effects suffered by would-be sniffers.

"They're inseparable"

Breaking News: Deadline November 11
November 1970, Volume 69, Number 22
Michigan State Medical Society

michigan medicine

U. C. SAN FRANCISCO
MEDICAL CENTER LIBRARY
DEC 7 1970

November Election Studied by Michigan Doctors; Many Changes Ahead in Legislature

The ramifications of the Nov. 3 election are still being studied by the Michigan Doctors Political Action Committee (MDPAC). The election will be a major topic of discussion at the MDPAC organizational meeting Jan. 21 at MSMS headquarters, when a new chairman and treasurer will also be selected.

The new legislature promises to be interesting, MDPAC members note.

The House of Representatives will still be controlled by the Democrats, but changes in leadership will take place. The Senate, formerly Republican-dominated, is now split evenly, with 19 Republicans and 19 Democrats in the membership.

Lieutenant Governor William Brickley, a Republican, will have the power to break ties in Senate legislative matters, but it remains to be seen whether he will have the same influence on the chairmanships and composition of committees. Democrats or Republicans could take those posts or the two parties could split them.

Two legislators holding influential legislative posts of interest to medicine, N. Lorraine Beebe, chairman of the Senate Health, Social Services and Retirement Committee, and Albert A. Kramer, chairman of the House Insurance Committee, were defeated in their bids for re-election.

Rep. William B. Fitzgerald, chairman of the House Public Health Committee, was re-elected, but is yet to be named to the chairmanship again. In a side issue, Alfred H. Whittaker, M.D., Detroit, the only Michigan physician active in state politics, was not a candidate for re-election to the Wayne State University Board of Governors.

The legislators returned to work following the election and will be concerned with organizing their party leadership and concluding their legislative calendar before breaking for Christmas vacation. All bills are currently alive, but if not acted upon by the Christmas adjournment, will be dead. The 76th two-year Michigan legislative session will convene on Jan. 13 at noon.

Former MSMS President, Doctor Sladek, Dies

Edward Frank Sladek, M.D., Traverse City, past president of MSMS who had completed more than a half-century of dedicated service to his community, died Oct. 2 at the age of 75. Further details will follow in the December issue.

Four Major Health Insurance Bills Under Current Congressional Study

Four major bills on national health insurance are currently before Congress. Our national legislative body reconvenes Nov. 16 in its first "lame duck" session in 20 years, and all four bills will be under consideration.

If no action is taken on the bills at that time, discussion of them will be carried over into the 92nd Congress meeting in 1971. Following is a synopsis of the bills and their intent, prepared by the Council on Legislative Activities of the AMA and reprinted from a recent special issue of the AMA's LEGISLATIVE ROUNDUP.

AMA's Medicredit Bill (Fulton-Broyhill, et. al.)—H.R. 18567......The AMA's Medicredit proposal is a three-part program providing basic health insurance protection for all individuals under 65 as well as a Peer Review Organization for quality and cost control.

Part A of Medicredit would provide for the issuance of health insurance certificates to those individuals or families whose income tax liability is $300 or less. Such a certificate entitles the owner to a qualified medical care insurance policy.

Part B of this proposal would establish a graduated scale of income tax credits to be allowed for the purchase of health insurance. The credits would be based on tax liability. The amount of the credit would be based on the amount of allowable premium, i.e., the cost of a qualified health care insurance policy.

A qualified health care insurance policy under Parts A and B would be issued by carriers registered with the appropriate state insurance body. The policy would also have to provide basic institutional and medical care benefits, including: 60 days of inpatient hospital services, including maternity and extended care facilities; emergency room or outpatient services; and all medical services, including diagnostic and therapeutic services when performed by or under the direction of an M.D. or D.O. in the hospital, home, office, or elsewhere.

Supplemental coverage could also be provided under a qualified program. This coverage could include: prescription drugs; additional days of inpatient hospital services; cost of blood in excess of three pints; other personal health services provided by or under the direction of an M.D. or D.O.; and up to $25,000 for hospital and medical expenses in addition to those provided by the basic policy after the first $300 of these additional expenses.

The coverage would be subject to certain deductibles and coinsurance provisions for Part B participants. An allowable supplement would be a provision to eliminate this deductible and coinsurance requirement.

A Health Insurance Advisory Board would establish regulations for the administration of the program and would set minimum federal standards for qualified insurance companies and plans. And a Federal Health Insurance Redemption Fund would be created to redeem the health insurance certificates issued under this program. Monies for the Fund would be appropriated from the general revenues.

Part C of Medicredit would establish a Peer Review Organization (PRO) program. The Secretary of HEW would contract with state medical societies for the operation of a PRO in each state. Under the program there would be first local and then statewide review by M.D.'s and D.O.'s of reports and allegations of improprieties bearing on reasonableness of charges, need for services rendered, or quality of services rendered by the provider. A finding against the provider could result in his suspension or exclusion from participation in the Federal Government health programs.

The AMA estimates that its Parts A and B will cost about $10 billion per year.

* * *

AFL-CIO's National Health Insurance Act (Griffiths)—H.R. 15779......This bill would provide comprehensive health care protection for all citizens and for those non-citizens who have resided in the U.S. for at least one year.

The benefits provided include primary and specialist physician services, outpatient psychiatric services, optometric services and eyeglasses, outpatient diagnostic, screening and preventive services, and other remedial care. Also included are dental services and inpatient hospital services, outpatient services when furnished by or on referral of a hospital or physician, skilled nursing home services, home health services, rehabilitation services, and emergency transportation.

There would be a $2 per visit charge for certain physician, other medical, and dental services and for home health services.

The patient's choice of physician would be made annually and would remain in effect for that year.

The regional agencies established by the bill would enter into agreements with city, county, or state medical societies, with single specialty groups or multispecialty groups of physicians or with nonprofit organizations for the provision of those services the contracting party is able to provide. Similar agreements would be entered into for dental and hospital services.

Payment to providers for services rendered under this proposal would be on a per capita basis, on a salary basis, or on a combination of these. Groups would be reimbursed on a per capita basis and would be free to provide for the reimbursement of their member physicians on a fee-for-service, per capita, salary, contract, or other basis. Groups entering into agreements for the provision of health care benefits would receive an allowance of 5% of their capitation amount for administrative expenses for use in implementing a plan for: peer review; improving the efficiency of delivery of services; continuing education; and other needed administrative services.

Other provisions call for: hospital payment on a per capita basis, or on the basis of budgeted costs, or on a combination of these; payments to vary depending on locality, differences in personnel, and make-up of the population served; payments to be made only to primary physicians and dentists (specialists would be reimbursed from funds received by the primary practitioner); and the program to be administered by a National Health Insurance Board.

Money for this program would be provided through a Health Services Fund. Payment to the Fund would be provided by an employee tax of 1% of wages and employer tax of 3% of wages plus a contribution by the Federal Government from general revenues equal to the employer, employee, and self-employment taxes imposed. The tax base would be increased to $15,000 by 1975.

The cost of this program has been estimated to be between $35 and $40 billion a year.

* * *

Committee of 100's Health Security Program (Kennedy, et. al.)—S. 4297......Senator Kennedy as a spokesman for the Committee for National Health Insurance (Walter Reuther's Committee of 100) introduced on August 27, 1970, S. 4297.

The Committee of 100's plan, called the "Health Security Program," includes these provisions: comprehensive health coverage, including payment of all necessary physician services, with surgery covered only if done by an appropriately qualified specialist and on proper referral; all necessary hospital services; skilled nursing home services (120 days per spell of illness); dental services for children with eligibility expanding in time to cover all persons; medicines from an established list (for inpatients and persons enrolled in group practice plans, for others only drugs for long-term or chronic illness will be covered); and other supporting services. There would be no maximum amount of benefits to be paid or days of care to be provided (except for skilled nursing homes).

The program would be financed from three sources: 40% from general revenues, 35% from employer payroll tax, 25% from individual's payroll taxes. These monies would be paid to a Health Security Trust Fund. Allotments would be made to local regions for physician payment. Priority would be given to salaried physicians in institutions, to those in comprehensive group practice prepayment organizations, and to others who agree to accept capitation payments. The remainder in the local fund would be used for payment of fee-for-service bills. If the fund is low, these last payments would be prorated. Other features of the Kennedy bill include: a Resources Development Fund to reorganize the delivery of health care emphasizing comprehensive prepaid group practice programs; national standards for participation by providers (both individual providers and institutions), including continuing education requirements; special incentives to induce providers to practice in rural or deprived areas; and active involvement of consumer groups in the development of health care programs and organizations.

The program would have cost $37 billion if it had been in effect in 1969. Estimates of the cost now are over $40 billion.

* * *

Medicare For All (Javits)—S. 3711......This bill entitled, "National Health Insurance and Health Services Improvement Act of 1970," would provide a system of national health insurance to be implemented by expanding the present Medicare program to include all individuals. The program is designed to be fully in effect by July 1, 1973. However, before then, it would cover the disabled, the unemployed, and the poor.

The bill would add coverage of maintenance drugs to the present Medicare benefits provided, with a fee of $1 per prescription imposed. The provider of a maintenance drug would be paid the reasonable drug charge which would be the acquisition allowance plus a dispensing allowance. Also included would be physical examinations for all and dental care for children under 8 years of age.

Under S. 3711, the Secretary of HEW would prescribe: standards of continuing education; and national minimum standards of licensure, or standards of qualification for the performance of major surgery or other designated specialty services. While the program would be administered by the Federal Government, the Secretary could enter into agreements with any state to allow state administration.

Delivery of health care could come about through a variety of mechanisms. The Secretary would be authorized to contract with comprehensive health service systems, with payment for the reasonable cost of the services or on a predetermined capitation basis. (A bonus would be allowed if costs are below the average costs for the services provided to a comparable population group outside the system.) The Secretary would also be authorized to contract with any carrier to provide health benefits equivalent to those provided under the program to individuals who elect to be covered by the carrier. Or, the Secretary could enter into agreements with employers for the provision of health care benefits to their employees. Such a plan would have to cover the employee and his dependents, would have to have at least 75% paid by the employer, and would have to provide benefits superior to those provided under Medicare.

A special account would be created in the Federal Health Insurance Trust Fund which would provide for the payment of benefits for those under 65. Funds to the special account would be attained through a tax on payroll with the wage base being increased to $15,000. The tax rate for employers and employees would increase from .7% in 1971 to 3.3% in 1975. The Federal Government would contribute an amount equal to one-half of the amount contributed by employers and employees.

Senator Javits has not provided cost estimates of his proposal. The Social Security Administration has estimated that the program would cost $66.4 billion in 1975, when fully implemented.

15 Physician Members of New Blue Shield Corporate Body Being Selected by Ballot of MSMS House

A ballot was mailed Nov. 13 to seated members of the 1970 MSMS House of Delegates asking them to select 15 members to the new Blue Shield Corporate Body.

At the annual meeting of the members of the Shield Corporation in Detroit, Sept. 22, the membership voted to amend Articles Four and Five of the Articles of Incorporation changing the composition of the Corporate Body and the Board of Directors. The changes were approved by the state attorney general and commissioner of insurance and became effective Oct. 2.

The deadline for ballots will be 10 a.m., Nov. 30 at the MSMS Headquarters and a tellers committee of the house will tabulate the returns. At least six of the present board members will be elected to help ensure continuity, as specified in the amended articles. Fourteen of the present board members have indicated a willingness to serve if elected.

The present Blue Shield Board will meet Dec. 16 to set the date for an official meeting of the new corporate body sometime in January to select its new board members. At that time the 36 new M.D. members of the corporate body will select 12 MDs to serve on the new board; with at least 6 of them coming from the present board.

The new corporate body will include 108 persons and the new board will number 36.

Judicial Commission Elections Underway

Dec. 1 is the deadline for return of ballots in the election of members to the MSMS Judicial Commission from Districts One, Five and Seven.

The ballots were mailed to all voting members in those districts on Oct. 15, asking them to select one of the following candidates from each district:

District One—John G. Graham, Jr., M.D., Grosse Pointe; Robert H. Hamburg, M.D., Detroit, and Alexander H. Hirschfeld, M.D., Detroit.

District Five—Sherman E. Andrews, M.D., Kalamazoo, and F. P. McQuillan, M.D., Jackson.

District Seven—Willis H. Huron, M.D., Iron Mountain, and George M. Wilson, M.D., Marquette.

michigan medicine

MICHIGAN STATE MEDICAL SOCIETY

Published semi-monthly, Trimonthly in December; 25 issues, by the Michigan State Medical Society as its official journal. Second class postage paid at East Lansing, Mich. and at additional mailing offices. Yearly subscription rate, $9.00. Printed in USA. All communications should be addressed to the Publications Committee, Michigan State Medical Society, 120 West Saginaw Street, East Lansing, Michigan 48823. © 1970 Michigan State Medical Society. Phone: Area Code 517, 337-1351.

Second Class Postage Paid at East Lansing, Mich. and at additional mailing offices.

UNIVERSITY OF CAL
LIBRARY SCH OF MED
THIRD & PARNASSUS AVE
SAN FRANCISCO CAL 94122

Attention Librarians: This publication is a regular issue of **MICHIGAN MEDICINE** and should be saved for binding later with the larger scientific issues of the journal.

michigan medicine

FEATURES IN THIS ISSUE

- The Michigan Physician, His Work Needs and Opportunities
- County Medical Societies Must Face Future Hospital Strikes
- A Viewpoint on Current Trends to Regulate Practice Standards

U. C. SAN FRANCISCO
MEDICAL CENTER LIBRARY
JAN 6 1971

One of the lovely faces of winter is depicted in this linoleum block print by Michigan artist, Gwen Frostic of Beulah. Mrs. Frostic's gracefully-executed prints in delicate hues are drawn from the fields, woods, water and wildlife around her studio perched high on a hill over Crystal Lake. Books and notepaper containing Mrs. Frostic's designs are on sale in hospital gift shops around Michigan.

Michigan State Medical Society
December 1970, Volume 69, Number 23

NOW... a new sponsored insurance plan

THE ULTIMATE IN INSURANCE PROTECTION

MSMS PERSONAL PRESTIGE POLICY

**DESIGNED FOR AND SPONSORED BY THE
MICHIGAN STATE MEDICAL SOCIETY**

Remember *Yesterday's* Liability Limits Invite Financial Disaster *Today.* The Answer to this Dilemma is Provided in This Comprehensive Policy.

Here are some of the things it does:

★ PROVIDES LIABILITY COVERAGE ABOVE BASIC INSURANCE IN AMOUNTS OF $1,000,000 TO $5,000,000

★ APPLIES TO ALL EXPOSURES SUCH AS PROFESSIONAL LIABILITY, AUTOMOBILE, OFFICE PREMISES, RESIDENCE, BOATS AND AIRCRAFT

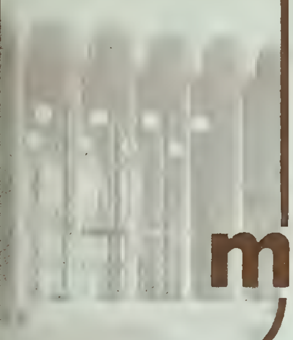
AND ALSO PROVIDES A MAJOR MEDICAL SECTION UP TO $25,000 TO SUPPLEMENT YOUR BASIC HEALTH PLAN

CALL US COLLECT: 517 484-2578 TO LEARN FIRST HAND HOW WE CAN PROVIDE YOU WITH THIS NEEDED COVERAGE AT A REASONABLE COST.

bps **BEN P. STRATTON AGENCY, INC.**
ESTABLISHED IN 1937

19400 WEST TEN MILE ROAD
SOUTHFIELD, MICHIGAN 48075
357-5083

107 N. BUTLER BLVD.
LANSING, MICHIGAN 48903
(517) 484-2578



Breaking News: Deadline Nov. 25
December 1970, Volume 69, Number 23
Michigan State Medical Society

michigan medicine

MSMS Members Working to Prevent Passage of Bill Allowing Chiropractic Services Under Blue Shield

Michigan physicians have been asked to discuss with their legislators the reasons why Senate Bill 1756 should not be passed to include chiropractors under Blue Shield.

A *MSMS Medigram* alert was sent November 18 to 600 MSMS and component society leaders to provide background on the bill to describe the opposition to this type of legislation from the American Public Health Association, HEW, AFL-CIO, National Council of Senior Citizens, etc. MSMS has opposed chiropractic as an "unscientific cult whose practitioners lack the necessary training and background to diagnose and treat human disease."

This bill was approved by the Senate 30-5 last June and on November 9 was reported out of the House Insurance Committee to the floor. Chairman of the Insurance Committee is Rep. Albert Kramer, who was defeated in the primary and will not be returning to the new Legislature in 1971.

Bennett Amendment on Peer Review Opposed by MSMS, AMA

As this issue goes to press, MSMS and AMA legislative leaders are watching the actions of the U.S. Senate Finance Committee and the Senate on the Bennett Amendment to the Social Security Amendments of 1970.

MSMS in a *Medigram* dated Nov. 20 asked the component medical societies and interested physicians to write to Senators Griffin and Hart asking that any possible action on all the Social Security Amendments be deferred until the next Congress.

MSMS and AMA have objected to the Bennett Amendment because it does not provide for the state medical societies to be included in any peer review system. The MSMS House of Delegates Resolution 107 instructed MSMS to send telegrams to the two Michigan senators recommending that state medical societies should have primary responsibility for originating peer review.

Interested physicians who are not on the special MSMS legislative mailing list for *Medigram* may obtain a copy of the Bennett Amendment issue, Vol. 7, No. 7, by writing to the MSMS Department of Government Relations.

Medic-Corps to Return to Action Feb. 1 in Lansing

Commencing with the week of Feb. 1, MSMS again will provide a different physician representative each week to take part in the society's legislative program at the Capitol Building in Lansing.

At its annual meeting in September, the MSMS House of Delegates voted to continue the Medic-Corps program throughout the 22 weeks it is estimated the 1971 Michigan Legislature will meet in its first session. Interested physicians are now being asked to volunteer for the program.

Additional AMA-ERF Contributions Asked To Meet Medical Schools' Needs

A special call is being issued to Michigan physicians to increase their contributions to the AMA's Education and Research Fund, in the face of growing demand for the funds by the nation's medical schools.

In 1969-70, Michigan physicians contributed substantially to the total of $25,265.51 raised for the AMA-ERF by the Woman's Auxiliary to MSMS. That was an increase of 25.8 percent over the past year's contributions.

The money contributed by Michigan physicians goes to Michigan medical schools, to be used at the discretion of the dean and the administration. At the 1970 MSMS Annual Session, formal presentation of checks was made to the deans of Michigan's three medical schools, with $3,475 going to MSU, $5,623 to WSU and $11,145 to the U-M.

In appreciation, John A. Gronvall, M.D., acting dean at the U-M Medical School, wrote: "You know, of course, how helpful these funds are to the medical school. They allow us to capitalize quickly on opportunities which would often be lost if we had to depend only on the categorical funds for legislative appropriations and research grants and contracts. We do sincerely appreciate the interest and efforts of the Society in this regard."

State-wide AMA-ERF chairman for Michigan is Mrs. Dean Carron, 1330 Glendaloch Circle, Ann Arbor 48104.

Special Session of House Set for Dec. 16

A special meeting of the MSMS House of Delegates will be held at 1:30 p.m. Dec. 16 at the Olds Plaza Hotel, Lansing.

The call for the meeting, issued Dec. 2 by Vernon V. Bass, M.D., speaker, explains that, "Since the mailing Nov. 12 of the ballots to designate the 15 doctors to the restructured Blue Shield corporate body, MSMS has received petitions and de facto petition-letters from more than 25 percent of the delegates for a special session.

"The purpose of this session will be to implement MSMS representation in the restructured corporate body of Michigan Medical Service, including the election of 15 physicians to the corporate body of Michigan Medical Service for one year terms by voting at this special House session or by mail ballot heretofore held but not tallied, as the House of Delegates deems appropriate."

Mott Foundation Makes Large Grant To WSU School of Medicine

A grant of $4,500,000 has been made to the Wayne State University School of Medicine by the Charles Stewart Mott Foundation of Flint. The grant will be used for construction of the C. S. Mott Center for Human Growth and Development, under the direction of the Department of Gynecology and Obstetrics.

Doctor Sladek Dies; Former MSMS President and Council Chairman

Doctor Sladek

Edward F. Sladek, M.D., former MSMS president and one of the Grand Traverse area's best-loved personalities, died Oct. 2 at the age of 75.

Doctor Sladek, who served as MSMS president in 1948, had completed more than a half-century of dedicated service to his community. He was director of rehabilitation medicine and chief of proctology at Munson Medical Center in Traverse City.

A graduate of the University of Illinois Medical School, Doctor Sladek had been practicing in Traverse City since 1919. He was a fellow of the American Proctologic Society and the International College of Surgeons.

Doctor Sladek was a charter member of the Michigan Heart Association, assisted in the establishment of Michigan Medical Service and served on its board for 14 years, and suggested and developed the Michigan Clinical Institutes held for several years by MSMS and the annual Michigan Rural Health Conferences.

He was a former chairman of The MSMS Council and served on the MSMS Public Relations Committee for 14 years.

CAPSULES

One of November's biggest events on the medical calendar was the talk before the Kent County Medical Society by Walter C. Bornemeier, M.D., president of the AMA. Doctor Bornemeier, a Chicago surgeon, spoke Nov. 10 to the local doctors' group, which also included Harold H. Hiscock, M.D., Flint, MSMS president, and Warren F. Tryloff, director of MSMS.

* * *

Plans are well underway for the 1971 Michigan Conference on Maternal and Perinatal Health, which will have a new location this year. Traditionally held in Flint, the conference is scheduled April 14-15 at the Olds Plaza Hotel in Lansing.

Darrell E. Statzer, M.D., Detroit, will be chairman of the conference for the second consecutive year.

The Council of Medical Staffs —What and Why?

By John R. Ylvisaker, M.D.
Pontiac (MSMS Treasurer)

The evolution of the concept of joining hospital medical staffs into a functioning professional-political entity is an interesting phenomenon on the American scene of organized medicine.

The purpose, initially, was to provide a base for the expression and the protection of the rights of physicians practicing in hospitals. The rationale for this was logical and appropriate, since it capitalized on existing organizations with established representation for the practicing physician. It also capitalized on the practical fact that the hospital medical staffs have by far the greatest continuous concentration of medical activity both in numbers of physicians and amounts of time spent by the physicians by virtue of day-to-day hospital-related functions.

The founding group of the Council of Medical Staffs in Louisiana directed attention to pressing hospital problems, having no other avenue of expression and redress. Notable successes were achieved in resolving inequities with the Joint Commission of Accreditation of Hospitals and with other agencies which imposed authoritarian demands.

Subsequently, however, attention has been turned to legislation, political activities, and matters more commonly viewed as the responsibility of the medical society, either county or state. The council in Louisiana operates outside of, and parallel to, the state medical society. The obvious and inevitable hazard would appear to be fragmentation of efforts, variance of policy and philosophy, loss of unity, and dissipation of effectiveness and authority.

Detroit Contemplating Councils

The idea has caught on and is being popularized and implemented in many areas. The Detroit area is now the scene of a sincere attempt to put the concept into action in Michigan.

Interestingly enough, an underlying stimulus for this movement in Detroit is the sentiment that the county and state medical societies no longer provide representation for nor are concerned with, the average practicing physician and his functioning unit of daily activity, the hospital medical staff. It is felt that a new and concerned parent body is essential to provide this representation. The feeling is so strong that participants are willing to create a new entity with the necessity for a duplicate political, administrative and financial structure. And again, the net result will probably be fragmentation and dissipation of effectiveness and authority.

Looking at the county and state medical societies, critically and dispassionately, one must acknowledge the validity to the criticisms implied by this search for a new and more responsive entity to represent the practicing physician. The following observations must be examined, and if accurate, must be attended to:

(1) County boundaries often do not correspond to functional areas of organized professional activity;

(2) The practical and operational scene of physician involvement has shifted over the years from county society to hospital medical staffs.

(3) In many areas, especially the large urban and suburban areas, county membership is perfunctory and accepted only for reasons of tradition and propriety.

(4) County society activity involves 10% or less of the actual membership and thus provides minimal representation of the views and needs of the membership.

(5) The state society and its elected bodies are a product of the county societies and thus may reflect the same failure of adequate representation.

(6) Many of the county society activities duplicate or parallel medical staff activities.

(7) Hospital staffs do not customarily find, or exchange, representation with the county or state society.

Re-evaluation Now Due

The time is long past for a critical study of organized medicine in Michigan to examine the objectives, the structure, the representation, the relevance of the state society and its components to the modern-day practice of medicine. Reorganization may be the direct outgrowth of such a study to accommodate the needs of the total membership. Certainly, as a part of whatever change is instituted, the medical staffs of hospitals must be directly involved and be provided an active voice. To avoid fragmentation and dissipation of funds, energies, and activities, this particular change, to include representation for medical staffs, must be a priority item of each county society and of the council of the state society.

A new organization is not necessary to accomplish this representation if realistic adaptation is instituted by the present organization.

MICHIGAN MEDICINE is published Semi-Monthly, Trimonthly in December; 25 issues, by the Michigan State Medical Society, 120 W. Saginaw, East Lansing, Mich. 48823. Second class postage paid at East Lansing, Mich. and at additional mailing offices.

LACTINEX®

LACTINEX

LACTINEX®

TABLETS &

GRANULES

- **to help restore and stabilize the intestinal flora**
- **for fever blisters and canker sores of herpetic origin**

Introduced to help reestablish the normal physiology of the intestinal tract in gastrointestinal disturbances[1], particularly diarrheas (including those resulting from antibiotic therapy), Lactinex is also useful for reestablishing the flora following bowel surgery, infant colic, mucous colitis, foul-smelling stools, pruritus ani, flatulence and hives.[2,3,4,5,6]

Lactinex contains a viable mixed culture of both *Lactobacillus acidophilus* and *L. bulgaricus* with the naturally occurring metabolic products produced by these organisms.

No untoward side effects have been reported to date.

Literature on indications and dosage available on request.

HYNSON, WESTCOTT & DUNNING, INC.

Baltimore, Maryland 21201

(#LX06)

LX

References:

(1) Siver, R. H.: CMD, **21**:109, September 1954. (2) Frykman, H. H.: Minn. Med., **38**:19-27, January 1955. (3) McGivney, J.: Tex. State Jour. Med., **51**:16-18, January 1955. (4) Quehl, T. M.: Jour. of Florida Acad. Gen. Prac., **15**:15-16, October 1965. (5) Weekes, D. J.: NY State Jour. Med., **58**:2672-2673, August 1958. (6) Ellis, S. and Spratt, J. S.: JOUR. AMER. GER. SOC., **18**:410-415, May 1970.

A urinary tract infection was eliminated last week

Intestinal monilial overgrowth has appeared this week

For women who are diabetic or debilitated, oral antibiotic therapy often sets the stage for monilial overgrowth in the intestine.

When you anticipate such a problem, take action with DECLOSTATIN 300. It combines the broad-spectrum potency of demethylchlortetracycline with the antifungal effectiveness of nystatin—it helps avoid monilial take-over. Experience has shown DECLOSTATIN to be highly useful for many women patients; individual culture studies will show exactly where this usefulness may best be applied.

It doesn't let monilia begin where bacteria end.

Declostatin® 300

Demethylchlortetracycline HCl 300 mg and
Nystatin 500,000 units Capsule-Shaped Tablets Lederle

Effectiveness: Because its antibacterial component is DECLOMYCIN® Demethylchlortetracycline, DECLOSTATIN should be equally or more effective therapeutically than other tetracyclines in infections caused by tetracycline-sensitive organisms. The antifungal component, nystatin, protects against superinfection by antibiotic-resistant fungal overgrowth (particularly monilia) in the intestinal tract.

Contraindication: History of hypersensitivity to demethylchlortetracycline or nystatin.

Warning: In renal impairment, usual doses may lead to excessive accumulation and liver toxicity. Under such conditions, lower than usual doses are indicated and, if therapy is prolonged, serum level determinations may be advisable. A photodynamic reaction to natural or artificial sunlight has been observed. Small amounts of drug and short exposure may produce an exaggerated sunburn reaction which may range from erythema to severe skin manifestations. In a smaller proportion, photoallergic reactions have been reported. Patients should avoid direct exposure to sunlight and discontinue drug at the first evidence of skin discomfort. Necessary subsequent courses of treatment with tetracyclines should be carefully observed.

Precautions: Overgrowth of nonsusceptible organisms may occur. Constant observation is essential. If new infections appear, appropriate measures should be taken. In infants, increased intracranial pressure with bulging fontanels has been observed. All signs and symptoms have disappeared rapidly upon cessation of treatment.

Side Effects: Gastrointestinal system—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. Skin—maculopapular and erythematous rashes; a rare case of exfoliative dermatitis has been reported. Photosensitivity; onycholysis and discoloration of the nails (rare). Kidney—rise in BUN, apparently dose-related. Transient, reversible, nephrogenic diabetes insipidus with excessive thirst and polyuria (rare). Hypersensitivity reactions—urticaria, angioneurotic edema, anaphylaxis. Teeth—dental staining (yellow-brown) in children of mothers given this drug during the latter half of pregnancy, and in children given the drug during the neonatal period, infancy and early childhood. Enamel hypoplasia has been seen in a few children. If adverse reaction or idiosyncrasy occurs, discontinue medication and institute appropriate therapy. Demethylchlortetracycline may form a stable calcium complex in any bone-forming tissue with no serious harmful effects reported thus far in humans.

Average Adult Daily Dosage: One tablet b.i.d. Should be given 1 hour before or 2 hours after meals, since absorption is impaired by the concomitant administration of high calcium content drugs, foods and some dairy products. Treatment of streptococcal infections should continue for 10 days, even though symptoms have subsided.

Lederle LEDERLE LABORATORIES, A Division of American Cyanamid Company, Pearl River, New York

450-9

michigan medicine

SCIENTIFIC EDITOR
John W. Moses, MD

EXECUTIVE EDITOR
Herbert A. Auer

MANAGING EDITOR
Judith Marr

ASSOCIATE SCIENTIFIC EDITORS
Jason Bodzin, MD
Detroit, House Staff
Frederick J. Cady, Jr., MD
Saginaw, Surgery
Robert M. Daugherty, MD
East Lansing, Basic Science
Harold E. DePree, MD
Kalamazoo, Medicine
Dean C. Elliott, MD
Petoskey, Otolaryngology
Tommy N. Evans, MD
Detroit, Obst.-Gyn.
E. Richard Harrell, MD
Ann Arbor, Dermatology
Dorin L. Hinerman, MD
Ann Arbor, Pathology
Samuel D. Jacobson, MD
Detroit, Medicine
Benjamin Jeffries, MD
Detroit, Psychiatry
Raymond S. Kurtzman, MD
Detroit, Radiology
A. Martin Lerner, MD
Detroit, Medicine
John C. Peirce, MD
Grand Rapids, Medicine
Frank H. Power, MD
Traverse City, Surgery
J. G. Turcotte, MD
Ann Arbor, Surgery
Alexander J. Walt, MD
Detroit, Surgery
Park W. Willis, III, MD
Ann Arbor, Medicine
Richard E. Wunsch, MD
Traverse City, Medicine

PUBLICATION COMMITTEE
Robert M. Leitch, MD
Chairman
Donato F. Sarapo, MD
Ann Arbor
Edward J. Tallant, MD
Detroit

MICHIGAN MEDICINE is the official organ of the Michigan State Medical Society, published under the direction of the Publication Committee. Published Semi-Monthly, Trimonthly in December; 25 issues, by the Michigan State Medical Society as its official journal. Second class postage paid at East Lansing, Mich. and at additional mailing offices. Yearly subscription rate, $9.00; single copies, 80 cents. Additional postage: Canada, $1.00 per year; Pan-American Union, $2.50 per year; Foreign, $2.50 per year. Printed in USA. All communications relative to manuscripts, advertising, news, exchanges, etc., should be addressed to Publication Committee, Michigan State Medical Society, 120 West Saginaw Street, East Lansing, Michigan 48823. Phone Area Code 517, 337-1351. © 1970 Michigan State Medical Society.

* * *

MICHIGAN MEDICINE welcomes original scientific manuscripts, news items, photographs, features and letters presenting comments on issues. Authors may write to the MSMS Headquarters to obtain detailed instructions for the preparation of scientific papers.

IN THIS ISSUE

SCIENTIFIC ARTICLES

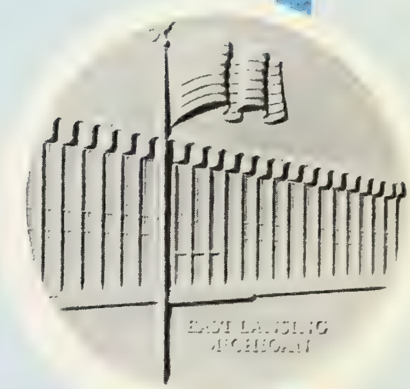
1063 The Michigan Physician: His Work Needs and Opportunities; by Floyd C. Mann, Ph.D.; John Kotre, Ph.D.; Anthony Reilly, Ph.D., and Neal A. Vanselow, M.D.
1071 Pulmonary Insufficiency; Marvin A. Sackner, M.D., Miami Beach
1075 Hypotension and the Shock Syndrome; Richard S. Ross, M.D., Baltimore

SPECIAL ARTICLES

1058 Present Trends Indicate More Regulation of Practice Standards; John W. Moses, M.D.
1093 Michigan Physicians May Face 1971 Draft; Judith Marr

OTHER FEATURES

1051 Breaking News
1060 msms leadership
1061 officers' page
1070 the viewbox
1074 drug and therapy problems
1077 perinatal tips
1078 monthly surveillance
1083 desk reference card
1088 medical care programs
1090 michigan mediscene
1092 about doctors
1101 in memoriam
1108 noted and quoted



MICHIGAN STATE MEDICAL SOCIETY
120 West Saginaw (P.O. Box 152)
East Lansing, Mich. 48823
Area Code 517, 337-1351

Editorial:

Present Trends Indicate More Regulation Of Practice Standards

By John W. Moses, M.D.
Scientific Editor

At this year's meeting of the House of Delegates of the Michigan State Medical Society the following resolution was adopted:

That the Michigan State Medical Society endorses the principle of voluntary life-long postgraduate study for all physicians and continues to accelerate the development of programs and incentives for such study.

In the last few years medical progress has outdistanced all the previous advances since the beginning of mankind. It is becoming exceedingly more difficult for each individual to keep abreast of all that is happening in his own chosen field. However, communications in lay press and other media are keeping the consumer well appraised of the "miracles" of today's medicine. The consumer (formerly called the patient) expects his provider (formerly called his doctor) to be well aware of all these new developments and expects all these developments to be available to him.

While we have been making changes in the technical aspects of medical care many changes have evolved in the delivery of medical care. The concept of the consumer paying directly to the provider for his care is becoming passé. Third party involvement in the financing of medical care, be it insurance or government, is the vogue of the day. The third party is a completely impersonal structure not involved directly with the interpersonal physician-patient relationships, but with the finances of medical care and the fulfillment of what they believe the miracles of modern medicine should be able to deliver.

The third parties are attempting to evolve methods of evaluating our competence and abilities. In some areas of the country the third party groups have already promulgated rules and guidelines concerning whom they will pay for services, based on such guides as board certification and hospital appointments, etc. If present trends continue we shall see more regulations pertaining to our standards of competence.

Organized medicine has for years been involved in the advancing, testing and assuring the competence of its members. Indeed the largest portion of the AMA budget is centered in its Council on Medical Education and its many subcommittees and duties. Organized medicine is well aware of the problems of continuing medical education and testing for medical competence. An individual may pass his board examinations (thus becoming board certified) and still not render competent care to his patients. By the same token, a man may not have had board training and may render superb medical care to his patient. What may be expected of a man in a larger metropolitan area, on the staff of a large teaching hospital, with many modalities at his disposal, cannot be expected of a man in a town of 3,500 population with a hospital of 50 beds and a three man staff. In like manner the continuing educational needs of the two men will differ. Similarly the educational needs of board certified men may differ within their own specialty, certainly the certified internist who concentrates his work in nephrology and the running of a chronic renal dialysis unit does not necessarily have to know the mucosal pattern of the jejunum in malabsorption syndromes.

At present some boards are considering or promulgating recertification examinations (e.g., Internal Medicine). At present these are to be purely voluntary, Will they remain voluntary? Will regulating groups, outside of organized medicine, seize upon this as another test of competence? Will hospitals seize upon this as a criteria for staff appointments and positions? It may be that in our fears of those assailing us, we are jeopardizing ourselves more than they are.

The A.A.G.P. for years did a magnificent job in their continuing education efforts, requiring proof of continuing education (giving the individual choices in his educational endeavor) as a requirement for membership. The Oregon State Medical Society recently enacted requirements for proof of continuing education as part of their requirements for membership. In their standards, all groups were considered and many options were made available for the individual. The A.M.A. has recently started a voluntary program with many options available.

It was the feeling of your house of delegates, that all physicians are aware of the need of continuing education, but each individual physician should be in a position to determine what the greatest needs are in his individual practice situation and how to best meet his needs.

It is to be hoped we will not need to set up mandatory requirements.

Join us on our South Pacific Adventure.

We leave March 11

We leave from Detroit

Come with us on our exciting two week adventure to the colorful lands Down Under . . . New Zealand . . . Australia . . . Tahiti.

All for only $998

Our two week South Pacific Adventure includes:

- Direct flights via chartered Pan Am 707 jet
- First class hotels with superb views
- Complete American breakfasts at your hotel
- Gourmet dinners at a choice of the finest restaurants
- Escort and five hosts always available to assist you
- Optional sightseeing tours each day
- No regimentation. Do as you please—when you please!

All this is yours for much less than the round trip regular air fare . . . truly a value you can't match anywhere.

Space is strictly limited on this exciting adventure. To confirm your reservations now, complete the coupon and mail it today!

SEND TO:

Michigan State Medical Society
120 W. Saginaw
P.O. Box 950
East Lansing, Michigan 48823

Enclosed is my check for $__________
($100 per person as deposit)

NAME__________

ADDRESS__________

CITY__________

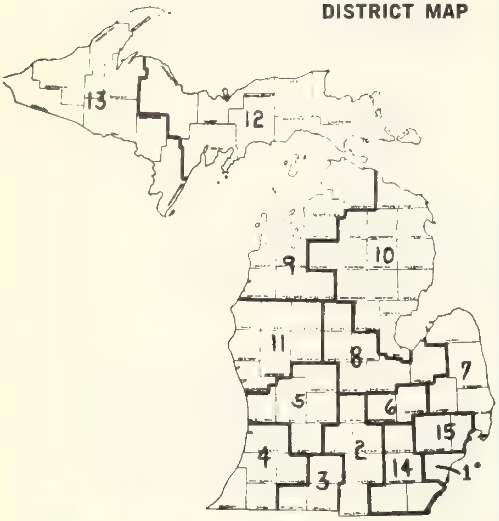
STATE__________

ZIP__________ PHONE__________

msms leadership

PRESIDENT	Harold H. Hiscock, M.D.	Flint
PRESIDENT-ELECT	Sidney Adler, M.D.	Detroit
SECRETARY	Kenneth H. Johnson, M.D.	Lansing
ASST. SECRETARY	Brooker L. Masters, M.D.	Fremont
TREASURER	John R. Ylvisaker, M.D.	Pontiac
ASST. TREASURER	C. Allen Payne, M.D.	Gd. Rapids
SPEAKER	Vernon V. Bass, M.D.	Saginaw
VICE-SPEAKER	James D. Fryfogle, M.D.	Detroit
PAST PRESIDENT	Robert J. Mason, M.D.	Birmingham
COUNCIL CHR.	Ross V. Taylor, M.D.	Jackson
VICE-CHAIRMAN	Brooker L. Masters, M.D.	Fremont

COUNCILOR DISTRICT MAP



First District Councilors: (Wayne County)
Edward J. Tallant, MD, Detroit
Ralph R. Cooper, MD, Detroit
Frank G. Bicknell, MD, Detroit
Milton R. Weed, MD, Grosse Pointe Park
Brock E. Brush, MD, Detroit

Second District Councilor: Ross V. Taylor, MD, Jackson
Counties: Clinton, Eaton, Hillsdale, Ingham, Jackson

Third District Councilor: Robert M. Leitch, MD, Union City
Counties: Branch, Calhoun, St. Joseph

Fourth District Councilor: W. Kaye Locklin, MD, Kalamazoo
Counties: Allegan, Berrien, Cass, Kalamazoo, Van Buren

Fifth District Councilor: Noyes L. Avery, MD, Grand Rapids
Counties: Barry, Ionia-Montcalm, Kent, Ottawa

Sixth District Councilor: Ernest P. Griffin, Jr., MD, Flint
Counties: Genesee, Shiawassee

Seventh District Councilor: John J. Coury, MD, Port Huron
Counties: Huron, Sanilac, Lapeer, St. Clair

Eighth District Councilor: A. Carl Stander, MD, Saginaw
Counties: Gratiot-Isabella-Clare, Midland, Saginaw, Tuscola

Ninth District Councilor: Adam C. McClay, MD, Traverse City
Counties: Grand Traverse-Leelanau-Benzie, Manistee, Northern Michigan (Antrim, Charlevoix, Cheboygan and Emmet combined), Wexford-Missaukee

Tenth District Councilor: Robert C. Prophater, MD, Bay City
Counties: Alpena-Alcona-Presque Isle, Bay-Arenac-Iosco, North Central Counties (Otsego, Montmorency, Crawford, Oscoda, Roscommon, Ogemaw, Gladwin and Kalkaska, combined)

Eleventh District Councilor: Brooker L. Masters, MD, Fremont
Counties: Mason, Mecosta-Osceola-Lake, Muskegon, Newaygo, Oceana

Twelfth District Councilor: William A. LeMire, Sr., MD, Escanaba
Counties: Chippewa-Mackinac, Delta-Schoolcraft, Luce, Marquette-Alger

Thirteenth District Councilor: Donald T. Anderson, MD, Wakefield
Counties: Dickinson-Iron, Gogebic, Houghton-Baraga-Keweenaw, Menominee, Ontonagon

Fourteenth District Councilor: Donato F. Sarapo, MD, Ann Arbor
Counties: Lenawee, Livingston, Monroe, Washtenaw

Fifteenth District Councilor: Sydney Scher, MD, Mount Clemens
Counties: Macomb, Oakland

DIRECTOR
Warren F. Tryloff..........East Lansing

GENERAL COUNSEL
Lester P. Dodd.................Detroit

LEGAL COUNSEL
A. Stewart Kerr ....Detroit

ECON. CONSULTANT
Clyde T. Hardwick ....Houghton

HISTORIAN
Wm. J. Stapleton, Jr., MD........Detroit

ASS'T HISTORIAN
Wm. M. LeFevre, MD.........Muskegon

SCIENTIFIC EDITOR
John W. Moses, MD.............Detroit

County Medical Societies Should Develop Plans To Handle Future Hospital Strikes

A hospital is closed.

Hurley Hospital, a 700-bed hospital operated by the City of Flint, was closed for one month by a strike of hospital workers belonging to Locals 1603 and 823 of the American Federation of State, County and Municipal Employees. Hospital employees have a right by law to organize into unions and also to strike if their demands cannot be resolved by negotiation or arbitration.

The immediate effects of the strike were 1) to discharge all patients that could be safely sent to their own homes; 2) to move to other hospitals all patients that needed hospital care with the exception of psychiatric patients, kidney dialysis patients, patients in intensive care, and patients in the infection unit; 3) to close an emergency room that cared for 3,000 - 3,500 patients per month; 4) to close all out-patient clinics that cared for many indigent patients in this community; and 5) to interrupt the intern-resident training program.

The medical community was not prepared for the strike, however the transfer of patients was carried out rapidly, effectively and safely to St. Joseph, McLaren, and Genesee Memorial Hospitals.

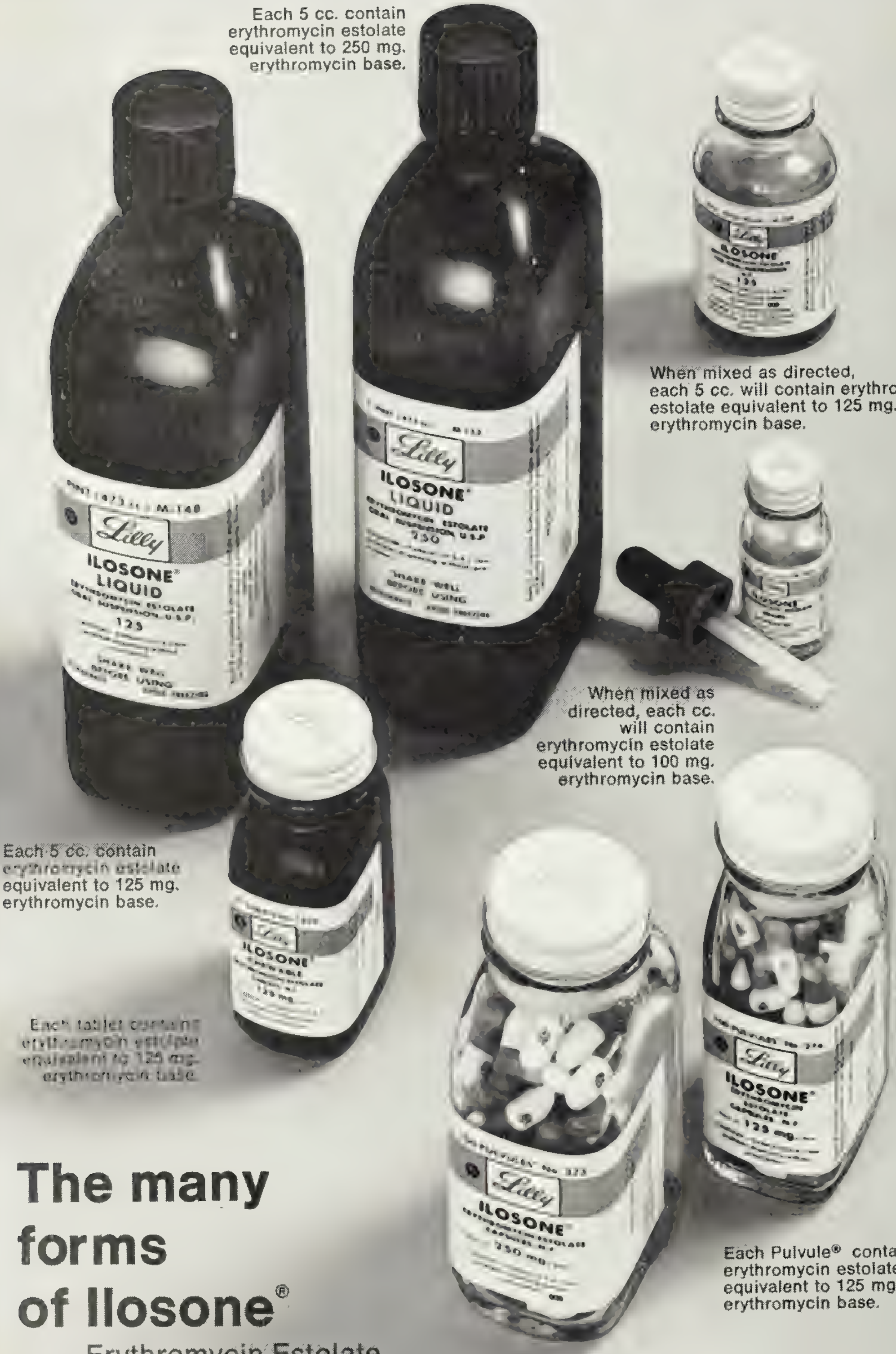
A lot of questions have to be answered:

1. Could the medical staff of Hurley Hospital have helped to prevent the strike?
2. What can be done with the intern-resident training program so that the interns and residents will not be unjustly punished in such a case?
3. What arrangements could be made so that the staff doctors of a closed hospital could have been given temporary privileges in other hospitals in the community? (Note: This was done in Flint with very little trouble.)
4. Isn't it time that county medical societies take a more active part in the decisions of the executive committees of the hospitals in their area, especially when these decisions affect the ability and right of their physician members to practice in these hospitals?

One remedy might be for the chiefs of staff of the various hospitals in the community to become active voting members of the boards of directors of the county medical societies so decisions of the hospital executive boards which affect the members of the county societies could then be brought up at these meetings.

The county medical societies in all counties that have more than one hospital should appoint a committee to make plans to handle the problems that might arise from a closed hospital.

H. H. Hiscock, M.D.
MSMS President


Lilly
ILOSONE
LIQUID
125
SHAKE WELL BEFORE USING
Lilly
ILOSONE
LIQUID
250
SHAKE WELL BEFORE USING
ILOSONE
125 mg.
ILOSONE
250 mg.
ILOSONE
125 mg.

Each 5 cc. contain
erythromycin estolate
equivalent to 250 mg.
erythromycin base.

When mixed as directed,
each 5 cc. will contain erythromycin
estolate equivalent to 125 mg.
erythromycin base.

When mixed as
directed, each cc.
will contain
erythromycin estolate
equivalent to 100 mg.
erythromycin base.

Each 5 cc. contain
erythromycin estolate
equivalent to 125 mg.
erythromycin base.

Each tablet contains
erythromycin estolate
equivalent to 125 mg.
erythromycin base.

Each Pulvule® contains
erythromycin estolate
equivalent to 125 mg.
erythromycin base.

Each Pulvule contains
erythromycin estolate
equivalent to 250 mg.
erythromycin base.

The many forms of Ilosone®

Erythromycin Estolate

Lilly

Additional information
available upon request.
Eli Lilly and Company
Indianapolis, Indiana 46206

910761

The Michigan Physician: His Work Needs and Opportunities

By Floyd C. Mann, Ph.D
John Kotre, Ph.D.
Anthony Reilly, Ph.D.
Neal A. Vanselow, M.D.
Ann Arbor

One of the major assumptions underlying our study of the Michigan physician and his continuing education was that it was necessary to understand the motivational forces important in his professional life. In the first article of this series, we saw that the typical physician was strongly motivated to perform well and to keep up to date by his own inner standards and by the presence of physician colleagues. In addition, we learned that doctors recognized by other physicians as having high medical-technical competence were even more stimulated by these two sources than were medical doctors in the state at large. The present article looks at motivation from another perspective, asking what needs the physician brings to his work and the extent to which his work provides the opportunity to implement those needs.

Work Needs

The four major groups of physicians in this study—the statewide sample of MDs, the statewide sample of DOs, the purposive sample of doctors' doctors (doctors chosen by other doctors in their hospitals as ones to whom they would bring personal or family medical problems), and the purposive sample of informal/formal consultants (doctors with whom others in their hospitals consult most often informally and formally) — were all asked to indicate how much importance they attached to each of 20 different kinds of opportunities which a professional's work might afford him. In responding, physicians were asked to disregard whether their present work arrangements provided the opportunity to fulfill the need in question. **Chart 1** shows what percent of the MDs attached great or utmost importance to each kind of need.

Sixty-five percent of the MDs stated that it was of great or utmost importance to them to have the opportunity to make full use of their present knowledge and skills; 59 percent indicated it was of great or utmost importance to grow and learn new knowledge and skills. In contrast, few of the MDs (5 percent) said it was as important to advance in administrative authority and status. The importance that medical doctors attached to each of the 20 specific work needs is shown by the order in which they appear in **Chart 1**; the alphabetic letters indicate the position each item originally had in the paper-and-pencil questionnaire.

Four principal groupings emerged when the responses of MDs to these items were factor analyzed in search of an underlying structure of needs. The names we gave these four factors, a brief description of each, and the specific items which constitute the factors are presented below:

(1) Need for *Self-Actualization.* Items in this factor expressed a concern for personal growth in the sense of acquiring new knowledge and skills while at the same time putting to use the knowledge and skills one already possessed. They expressed a concern for growth both in oneself and in others. Specifically, these needs were . . .

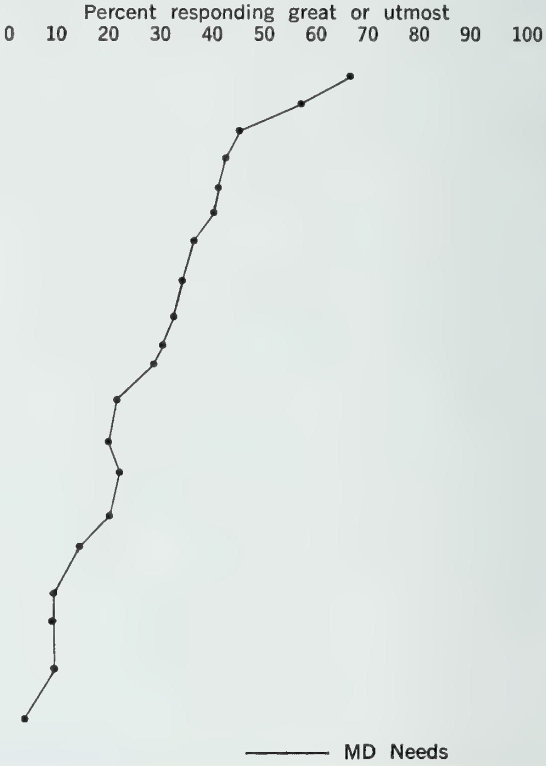
. . . to grow and learn new knowledge and skills (.70)
. . . to teach others to learn and develop their full potential (.69)
. . . to work on difficult and challenging problems (.67)
. . . to have the freedom to carry out my ideas (.65)

scientific papers

Doctors Mann, Kotre and Reilly are with the Center for Research on Utilization of Scientific Knowledge, and Dr. Vanselow is with the Department of Postgraduate Medicine. All are at the University of Michigan. This is the second of a series of articles reporting the principal findings from a study of the Michigan Physician and His Continuing Education. For study purpose, design, and illustrative findings see November issue of **Michigan Medicine.**[1] This research was supported by the Michigan Association for Regional Medical Programs, Contract Number 69-5-23.

CHART 1

Listed below are different kinds of opportunities which a professional's work might afford him. How much **importance** would you personally attach to each of these? (Disregard whether or not your present work arrangements provide them.)



a) To make full use of my present knowledge and skills	65%
b) To grow and learn new knowledge and skills	59
g) To work with colleagues of high technical competence	45
h) To have congenial associates as colleagues	43
m) To have the freedom to carry out my ideas	43
t) To help my community be a better place to live	42
i) To work in association with supportive personnel of high technical competence	39
l) To work on difficult and challenging problems	34
c) To teach others to learn and develop their full potential	33
f) To advance in the professional respect of colleagues	32
k) To build my professional reputation in the community	31
q) To build the reputation of the hospital with which I am associated	22
d) To earn a good salary	21
r) To contribute to the reduction of the nation's health problems through developing local facilities	21
n) To contribute to broad technical knowledge in my field	20
p) To work on problems of central importance to the medical field	16
o) To work on problems of central importance to the hospital	10
j) To associate with the most important and influential people related to my hospital	10
s) To be given credit for what I contribute to the functioning of the hospital with which I am associated	10
e) To advance in administrative authority and status	5

...to make full use of my present knowledge and skills (.63)

...to contribute to broad technical knowledge in my field (.63) *

(2) Need for *Professional Support*. This cluster of needs centered on the concern that one was working in association with colleagues who were both technically competent and personally supportive. Specifically, the factor included needs...

...to work with colleagues of high technical competence (.72)

...to have congenial associates as colleagues (.65)

...to work in association with supportive personnel of high technical competence (.50)

(3) Need to *Contribute to Society*. A third grouping of items evinced a need to contribute to the development of medical/social systems of which the physician was a part: the community, the nation, the hospital, and the medical field. Specifically, this factor incorporated needs...

...to contribute to the reduction of the nation's health problems through developing local facilities (.79)

...to help my community be a better place to live (.69)

...to work on problems of central importance to the medical field (.65)

...to work on problems of central importance to the hospital (.64)

...to build the reputation of the hospital with which I am associated (.61)

(4) Need for *Status*. A final factor manifested a concern with advancing in the status hierarchy and acquiring the benefits (respect, power, money) that come with high status. The following specific needs loaded most heavily on this factor...

...to advance in administrative authority and status (.72)

...to be given credit for what I con-

---

* The number after each item is its loading on the factor being described. A high factor loading does not mean medical doctors attached great importance to the item, but that the item is central to the factor being described. For the reader who is not familiar with factor analysis, see L.L. Thurstone, *Multiple Factor Analysis*.[2]

TABLE 1

Significant MD-DO Differences in Work Needs

	Percent of DOs attaching great or utmost importance	Percentage points different from MDs
Need to Contribute to Society		
...to help my community be a better place to live	58	+16
...to build the reputation of the hospital with which I am associated	37	+15
...to contribute to the reduction of the nation's health problems through developing local facilities	33	+12
...to work on problems of central importance to the hospital	15	+ 5
Need for Status		
...to build my professional reputation in the community	43	+12
...to earn a good salary	28	+ 7
...to advance in the professional respect of colleagues	22	−10
...to be given credit for what I contribute to the functioning of the hospital with which I am associated	14	+ 4
...to advance in administrative authority and status	8	+ 3
Need for Self-Actualization		
...to have the freedom to carry out my ideas	46	+ 3
...to contribute to broad technical knowledge in my field	27	+ 7
Need for Professional Support		
...to work with colleagues of high technical competence	30	−15

tribute to the functioning of the hospital with which I am associated (.66)

...to associate with the most important and influential people related to my hospital (.65)

...to build my professional reputation in the community (.50)

...to earn a good salary (.46)

...to advance in the professional respect of colleagues (.43)

Examining the replies of medical doctors in the light of these four factors, we find that needs for self-actualization and professional support were more important than those for contributing to society and advancing in status. An average of 42 percent of the MDs attached great or utmost importance to the six self-actualization items and an identical percentage to the professional support items. Five of the six self-actualization items appear among the top nine items shown in **Chart 1**, and all three of the professional support items are in the top seven.

Less concern was shown by medical doctors for contributing to society. An average of 22 percent attached great or utmost importance to the five items constituting this factor. Four of these items appear among the lower nine in **Chart 1**.

Least concern of all was reported by medical doctors for the six needs involving status advancement. Only 18 percent, on the average, considered these of great or utmost importance. None of the six status items fall among the top nine items in **Chart 1**.

DO's Work Needs

In many respects the pattern of professional work needs shown by the doctors of osteopathy was similar to that of the MDs. There were, however, some differences that were significant both statistically and conceptually. As is shown in **Table 1**, the DOs differed most from the MDs in expressing a greater need to contribute to society and a greater need for status advancement.

A significantly higher proportion of DOs than MDs had high professional work needs to help their community be a better place to live, to build the reputation of their local hospital, to aid in the reduction of the nation's health problems through developing local facilities, and to build their professional reputation in the community. These were the items showing the largest positive difference between the two groups.

On two items the DOs expressed markedly less need than the MDs in the state at large: to advance in the professional respect of colleagues, and to work with colleagues of high technical competence. One interpretation of this is that the DOs—like MDs in general practice—are satisfied that their principal contribution lies in serving the health needs of their communities. They do not want or expect to be working with and advancing in the respect of colleagues who are highly compe-

TABLE 2

23. We would like to know to what extent your present work as a physician actually provides an **opportunity** for each of the factors listed below.

	PERCENT responding GREAT or UTMOST:			
	Medical Doctors	Doctors of Osteopathy	Doctors' Doctors	Informal/formal Consultants
(a) Making full use of my present knowledge and skills	46	39**	61**	64**
(h) Having congenial associates as colleagues	35	32**	49**	52**
(d) Earning a good salary	33	40**	46**	55**
(m) Having the freedom to carry out my ideas	32	23**	36**	40**
(k) Building my professional reputation in the community	29	36**	42**	53**
(g) Working with colleagues of high technical competence	28	20**	31	39**
(b) Growing and learning new knowledge and skills	27	25	31	29*
(l) Working on difficult and challenging problems	24	18**	37**	46**
(t) Helping my community be a better place to live	24	28**	28**	32*
(f) Advancing in professional respect of colleagues	22	16**	36**	42**
(c) Teaching others to learn and develop their full potential	21	18**	33**	37**
(i) Association with supportive personnel of high technical competence	21	17**	19	22**
(j) Association with the most influential and important people related to my hospital	21	16	23**	29**
(q) Building the reputation of the hospital with which I am associated	20	28**	29**	37**
(o) Working on problems of central importance to the hospital	16	16	22**	28**
(r) Contributing to the reduction of the nation's health problems through developing local facilities	12	14	13	18**
(s) Being given credit for what I contribute to the functioning of the hospital with which I am associated	12	7**	14**	19**
(e) Advancing in administrative authority and status	10	10	17**	26**
(n) Contributing to broad technical knowledge in my field	10	10	8	15**
(p) Working on problems of central importance to the medical profession	10	9**	10	19**
Average, No Response***	7	5	1	1
N =	919	183	96	89

---

*The mean of this distribution is significantly different from the mean of the medical doctors' distribution at the .05 level (t-test, two-tailed). On occasion, this significant mean difference is not reflected in the figures above, which present only the percentage of respondents in the upper two categories of the distribution.

**The mean is significantly different at the .01 level (t-test, two-tailed).

***The no response rate averaged for the twenty items.

tent in a technical sense. To do so would require that they become specialists, and this they do not value as highly important for themselves. Other data that we have support this interpretation: medical doctors in general practice were similar to DOs in attaching less importance than MD specialists to these two needs.

Work Needs of Doctors' Doctors And Informal/Formal Consultants

The two groups of doctors recognized by other physicians in their hospitals as having high medical-technical competence were asked the same questions as the general samples of MDs and DOs. The replies of doctors' doctors differed significantly from those of MDs in six instances, five items expressing greater need. The replies of the informal/formal consultants differed significantly from those of MDs on fourteen specific items, each time expressing greater need. Because the consultants differed from MDs in more respects than did the doctors' doctors, we will discuss their responses first.

In the case of three principal groupings of needs—for self-actualization, for professional support, and for making a contribution to society—informal/formal consultants were stronger than medical doctors. On every item constituting these factors, a larger proportion of consultants than medical doctors attached great or utmost importance, and in all cases save two (Self-Actualization Item a and Contribute-to-Society Item t), the proportion was significantly larger.

It is instructive to note the specific items on which consultants showed the greatest difference from the sample of medical doctors. They are:

. . . to teach others to learn and develop their full potential (19 percentage points higher than MDs)

. . . to grow and learn new knowledge and skills (14 percentage points higher than MDs)

. . . to work on difficult and challenging problems (14 percentage points higher than MDs)

Each of these items is in the Self-Actualization group and each has to do with gaining new knowledge or competencies. The item showing the greatest difference reveals a strong need on the part of informal/formal consultants to teach other physicians.

It was in the need for status that consultants failed to show sharp differences from the general sample of medical doctors. They were higher on two status items (advancing in the professional respect of colleagues and in administrative authority and status), but in four others there were no significant differences between them and medical doctors. The consultants were like the DOs in showing more concern than MDs for contributing to society. They were dissimilar from DOs, however, in showing more need for self-actualization and professional support and less for advancing in status.

The replies of doctors' doctors were generally in the same direction as those of consultants but they did not exhibit as much need. Thus, significantly more doctors' doctors than medical doctors attached great or utmost importance to two of the six Self-Actualization items (l and c) and to three of the Contribute-to-Society items (t, q, o). There were not significantly more, however, who found any of the three Professional Support items of great or utmost importance, and there were significantly fewer doctors' doctors than medical doctors who found one Status item (j) as important.

Work Opportunities

Having looked at the importance that physicians placed on different kinds of opportunities which a professional's work might afford him, we can now approach the question of whether these work needs were being met. In a 20-item question analogous to the needs question with which we have just become familiar, all physicians were asked to what extent their present work actually provided an opportunity to meet their needs. **Table 2** presents the basic findings obtained through this question.

A few facts are immediately evident:

(1) DOs generally reported they had fewer opportunities than MDs. On 10 of the 14 items on which there is a significant difference between the two groups, fewer DOs than MDs said their work as a physician actually provided them the opportunities which they thought were important.

(2) The responses of the doctors' doctors indicated they had more opportunities than the MDs. On 14 of the 20 items, significantly more doctors' doctors than MDs stated they found opportunities provided by their work, and in half of these cases the differences ranged from 12 to 15 percentage points.

(3) The opportunities afforded consulting physicians by their present work appeared to be the greatest of all. In all 20 cases, significantly more consultants than medical doctors said that opportunities were available to them. Some of these differences amounted to as much as 20 percentage points in favor of the situations in which the consultants found themselves. On all 20 items, too, a larger percentage of consultants than osteopaths stated their work provided them great or the utmost opportunity, and on 19 of 20 items this percentage was greater than that of doctors' doctors.

While these differences among groups are interesting, a more relevant question can be answered by putting together replies to both questions we have been discussing, the one concerning work needs and the one involving work opportunities.

The Extent to Which Physicians' Work Needs Are Met

Chart 2 shows the relationship between how much importance MDs attached to different kinds of opportunities which a professional's work might afford him and the extent to which their present work as physicians actually provided an opportunity to meet these work needs.

MDs indicated that opportunities present in their work fell short of their needs for 15 of the 20 items in **Chart 2**. The gap between expressed need and perceived opportunity—measured by asking the physicians to express their answers on a common scale of five alternatives—varied markedly among the needs. The greatest percentage point difference for MDs was found between the need and the opportunity to grow and learn new knowledge and skills. In general, the more important a particular need was, the less that need was being met. The two needs that were more than amply met were "to earn a good salary" and "to associate with the most important and influential people related to my hospital." It is worth noting that these were status needs—and status needs were more fully met for MDs than were needs for self-actualization or professional support.

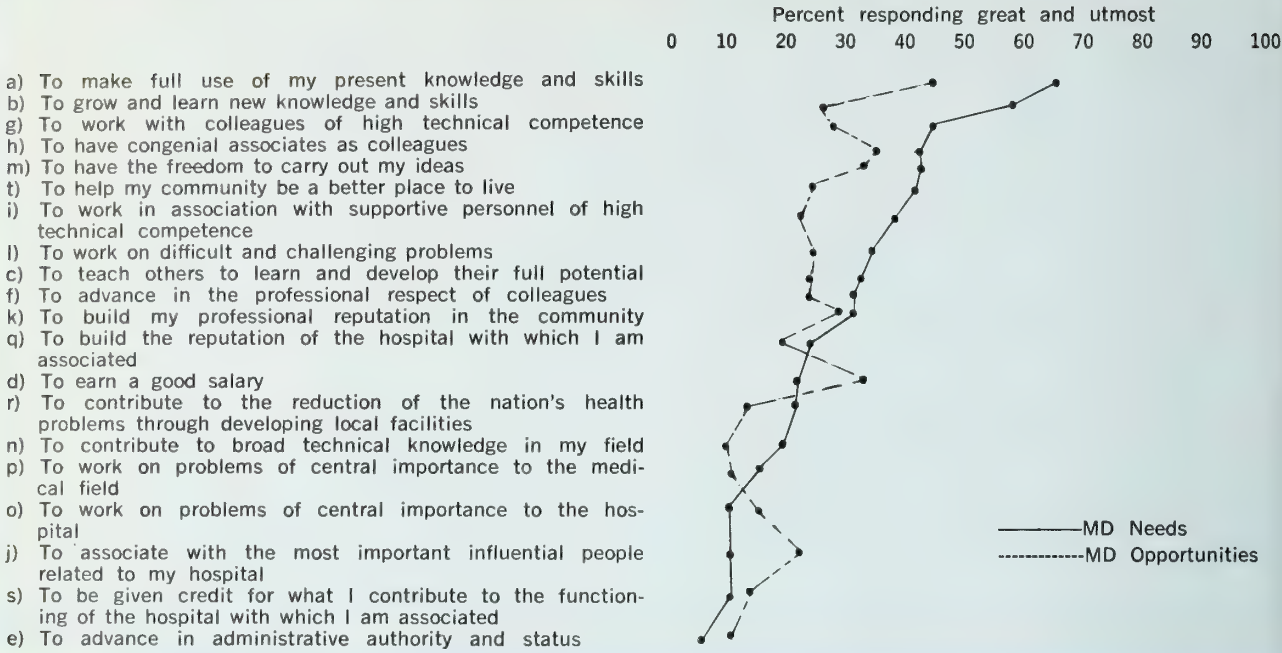
The DO's Needs/Opportunities Gap

The discrepancy between needs and opportunities for DOs was even larger than that for the MDs. On 16 of 20 items, opportunities provided by work were not as great as the needs expressed by DOs, and on six of these items the percentage point differences were 21 or more:

Item	Percentage Point Difference (Opportunities minus Needs)
To grow and learn new knowledge and skills	−33

CHART 2

Relationship Between Work Needs and Work Opportunities



To help my community be a better place to live	−30
To have the freedom to carry out my ideas	−23
To teach others to learn and develop their full potential	−22
To make full use of my present knowledge	−21
To work in association with supportive personnel of high technical competence	−21

Like the MDs, the DOs felt their work provided few opportunities to meet their needs for self-actualization: four of the six items above are in the self-actualization cluster. Again, "to earn a good salary" was the specific need that was more than met. Unlike the MDs, however, DOs felt a considerable gap between the need they had to contribute to the reduction of the nation's health problems through developing local facilities and the opportunity presented them to do so.

Table 3 shows the extent to which work needs and opportunities were matched for the DOs; data are also shown for the MDs, the doctors' doctors, and informal/formal consultants.

Criterion Physicians' Needs/Opportunities Gap

In general, the amount of discrepancy between work needs and opportunities for the criterion physicians appeared to be what it was for the sample of medical doctors (**Table 3**). Most distinctive about the replies of the doctors' doctors and the consultants were:

(1) Each group felt less of a gap than MDs or DOs between the need and opportunity to make full use of their present knowledge and skills.

(2) The consultants in particular, but also the doctors' doctors, were greatly dissatisfied with the extent to which their need to grow and learn new knowledge and skills was being met.

(3) Each group indicated their opportunity to earn a good salary was a good deal greater than their need to do so.

All in all, few of the findings regarding the gap between physicians' needs and the opportunities available to them were surprising. The most significant finding for the continuing education of physicians was that the need of all the responding physicians to grow and learn new knowledge and skills was much greater than the extent to which their present work actually provided them this opportunity.

Summary

In this article we have begun to explore some of the motivational forces important in the physician's professional life. This was done on the assumption that a better understanding of his needs and the opportunities presently available to him may give important leads as to how to improve programs of continuing education.

TABLE 3

Percentage Point Difference Between Work Needs and Work Opportunities For Four Groups of Physicians

	Medical Doctors	Doctors of Osteopathy	Doctors' Doctors	Informal/formal Consultants
a) To make full use of my present knowledge and skills	−19	−21	−12	−10
b) To grow and learn new knowledge and skills	−32	−33	−35	−44
g) To work with colleagues of high technical competence	−17	−10	−15	− 8
h) To have congenial associates as colleagues	− 8	− 9	− 3	− 4
m) To have the freedom to carry out my ideas	−11	−23	−14	−12
t) To help my community be a better place to live	−18	−30	−25	−16
i) To work in association with supportive personnel of high technical competence	−18	−21	−22	−22
l) To work on difficut and challenging problems	−10	−19	− 7	− 2
c) To teach others to learn and develop their full potential	−12	−22	−14	−15
f) To advance in the professional respect of colleagues	−10	− 6	− 3	− 4
k) To build my professional reputation in the community	− 2	− 7	− 8	−15
q) To build the reputation of the hospital with which I am associated	− 2	− 9	− 4	+ 2
d) To earn a good salary	+12	+12	+24	+29
r) To contribute to the reduction of the nation's health problems through developing local facilities	− 9	−19	− 7	− 5
n) To contribute to broad technical knowledge in my field	−10	−17	−11	−14
p) To work on problems of central importance to the medical field	− 6	− 7	− 7	− 2
o) To work on problems of central importance to the hospital	+ 6	+ 1	+ 5	+ 7
j) To associate with the most important and influential people related to my hospital	+11	+ 6	+16	+19
s) To be given credit for what I contribute to the functioning of the hospital with which I am associated	+ 2	− 7	+ 5	+ 9
e) To advance in administrative authority and status	+ 5	+ 2	+ 9	+16

NOTE: A plus sign above means there is more opportunity than need, a negative sign the reverse.

The specific work needs to which most physicians attached great or utmost importance were:

...to make full use of my present knowledge and skills

...to grow and learn new knowledge and skills

All four groups of respondents ranked these needs first and second in a list of 20 specific needs. Significantly more informal/formal consultants than MDs in the state at large expressed a need to grow and learn new knowledge and skills.

A factor analysis of MD replies to the 20 items yielded four principal groupings of needs. These were:

...need for self-actualization

...need for professional support

...need to contribute to society

...need for status

The first two of these were found to be high in mportance for MDs, while the latter two were of ess importance. Compared with MDs, more DOs expressed needs to contribute to society and to advance in status; more doctors' doctors thought self-actualization and contributing to society were important; and more consultants felt strong needs or self-actualization, professional support, and making a contribution to society.

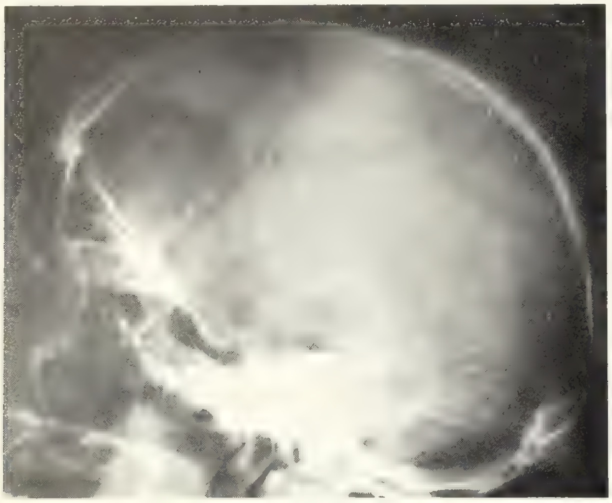
The opportunities that their present work as physicians actually provided them varied markedly among the four groups of physicians included in this study. Informal/formal consultants reported having more opportunities than doctors' doctors, who in turn said they had more than the general sample of MDs. Osteopaths reported having the fewest opportunities of all four groups.

Analysis of the discrepancy between the expressed needs and the perceived opportunities of physicians revealed a considerable gap for all groups of respondents, with the discrepancies being largest for DOs. Particularly important for continuing education programming was the finding for all physicians—the MDs, DOs, and the most highly competent medical doctors—the greatest discrepancy between work need and opportunity concerned growth and the learning of new knowledge and skills.

References

1. Mann, Floyd C., John Kotre, Anthony Reilly, and Neal Vanselow. The Michigan physician and continuing education. *Michigan Medicine,* November, 1970.
2. Thurstone, L.L. *Multiple Factor Analysis.* Chicago: University of Chicago Press, 1947.

Doctors, expand your knowledge about radiology by studying this monthly column prepared by the chief radiologist at Detroit Memorial Hospital.



The Viewbox

By Raymond S. Kurtzman, M.D.
Detroit

DIAGNOSIS:

OSTEOPOROSIS CIRCUMSCRIPTA (Paget's Disease)

X-RAY FINDINGS:

There is a large area of bone destruction involving the anterior portion of the skull.

DISCUSSION:

Osteoporosis Circumscripta is an early manifestation of Paget's Disease of bone, recognized most often in the skull, but also occurring in the tibias, sacrum, and elsewhere in the skeleton. Typically, there is a large area of bone destruction, usually asymptomatic. When followed over a period of years, the destructive area will change to the more widely recognized osteoblastic form of the disease. In Paget's Disease of bone, there is always a component of bone destruction along with bone production and the restructuring of the trabecular pattern. In Osteoporosis Circumscripta, the destructive elements are dominant. The lesion can be differentiated from metastasis by its large size, lack of associated symptoms, and occasionally the presence of productive lesions elsewhere in the skeleton.

REFERENCE:

Kohler and Zimmer: Borderlands of the Normal and Early Pathologic in Skeletal Roentgenology, Grune and Stratton 1968 p28

Doctor Kurtzman is an associate scientific editor of **Michigan Medicine.**

STATEMENT OF OWNERSHIP, MANAGEMENT AND CIRCULATION

Statement required by the Act of October 23, 1962; Section 4369, Title 39 of the United States Code showing the Ownership, Management and Circulation of Michigan Medicine, published Semi-monthly, Tri-monthly in December, 25 issues, mailed at East Lansing, Michigan in Ingham County for December 1, 1970.

1. The office of the publisher is located at 120 West Saginaw Street, East Lansing, Michigan 48823.
2. The general business office of the publisher is located at 120 West Saginaw Street, East Lansing, Michigan 48823.
3. The publisher is the Michigan State Medical Society. The Scientific Editor is John W. Moses, M.D., Mt. Carmel Mercy Hospital, Detroit, Michigan 48235; The Managing Editor is Judith Marr, 120 West Saginaw Street, East Lansing, Michigan 48823; The Executive Editor is Herbert A. Auer, 120 West Saginaw Street, East Lansing, Michigan 48823.
4. The owner is the Michigan State Medical Society, 120 West Saginaw Street, East Lansing, Michigan 48823.
5. The known bondholders, mortgagees, and other security holders owning or holding 1 percent or more of total amount of bonds, mortgages, or other securities are: None.
6. A. The total number of copies printed averages 8,350 per issue with a single issue nearest to filing date accounting for 8,263 copies.
   B. Paid circulation:
   7,478 subscriptions by mail, these being the active members of the Michigan State Medical Society who receive subscriptions.
   C. Sales to dealers, number none.
   D. Free distribution by mail carrier or other means: 550.
   E. Total number of copies distributed is 8,028.

I certify that the statements made by me above are correct and complete.

Wellman Press, Inc.
For the Publisher

Pulmonary Insufficiency

By Marvin A. Sackner, M.D.
Miami Beach

Pulmonary insufficiency occurs acutely or chronically under conditions which generally include in whole or in part signs of breathlessness, obstruction of airways and retention of secretions. Institution of proper therapy calls for a prompt integration of the history, physical examination and laboratory tests.

The features of most historic significance are concerned with sputum and wheezing. For example, it is difficult to make a diagnosis of chronic bronchitis without eliciting a history of sputum production on arising in the morning. A yellow or greenish color to sputum often signifies acute bronchopulmonary infection. Sudden cessation or marked reduction of sputum volume in a patient chronically bringing up sputum may indicate retained secretions or mucoid impaction. Gradual reduction of sputum volume over months or years accompanied by dyspnea may signal the development of pulmonary emphysema. Wheezing is associated with bronchial asthma or bronchitis; it also occurs in severe congestive heart failure. Swelling of the ankles may be the result of cor pulmonale or mechanical obstruction of the inferior vena cava by depressed diaphragms. Smoking habits, occupational background and exposure to noxious gases, fumes, or dusts are helpful in establishing an etiologic diagnosis.

The decision to employ a specific means of mechanical aid to ventilation is most dependent upon the sensorium of the patient. Conservative measures are preferred when the patient is mentally alert regardless of the disturbances in arterial blood gases. The breathing pattern is important in establishing whether reassurance, intermittent positive pressure breathing with bronchodilators or intubation are indicated. Short gasping inspirations in patients with obstructive airway disease may be caused by an anxiety reaction or acute bronchopulmonary infection. Prolongation of expiration occurs in bronchospasm and in emphysema. Occasionally, the sole sign of airway obstruction is vigorous contraction of the abdominal rectus muscles during expiration. Ausculation of the chest for wheezes, rales and audibility of breath sounds is helpful in the differential diagnosis of bronchospasm, congestion, fibrosis, pneumonitis and pneumothorax. A tracheal wheeze may result from the tracheobronchial collapse due to emphysema or to upper airway obstruction.

Analysis of the arterial blood gases is a mandatory part of the clinical examination in every patient with pulmonary insufficiency (for detailed description of arterial blood gas interpretations see Sackner, *Medical Times* 95:79, 1967). Important measurements obtained from the arterial blood analysis include pH, carbon dioxide tension (pCO_2), base excess, oxygen tension (pO_2) and oxygen saturation. The blood pH is normally fixed between 7.38 and 7.42. It is affected by a change in pCO_2 and an accumulation of non-volatile acids or bases. Arterial pCO_2 ranges from 38-42 mm Hg and is inversely proportional to alveolar ventilation. Base excess is normally zero; a positive value indicates a base excess or a non-volatile acid deficit, a negative value indicates a base deficit or a non-volatile acid excess. The base excess can theoretically be determined by titration with a strong acid to a pH of 7.40 at a pCO_2 of 40 mm Hg and a temperature of 38° centigrade. In practice, base excess is determined indirectly by calculation from a nomogram using values for pH, pCO_2 and hemoglobin concentration. The base excess should be considered as the indicator of metabolic and the pCO_2 that of respiratory disturbances. A blood pH below 7.38 indicates acidosis. If the pCO_2 is greater than 42 mm Hg a respiratory acidosis exists whereas if the base excess is less than -3 (i.e. -4, -5, -6 etc.) a metabolic acidosis is present. A positive base excess (+3 or greater) associated with a respiratory acidosis generally indicates that in whole or part the respiratory acidosis has been chronic.

The usual arterial blood gas disorders in pulmonary insufficiency involve hypoxemia and respiratory alkalosis or acidosis. Respiratory alkalosis and hypoxemia are often found in the early stages of status asthmaticus and in atelectasis. Many patients with obstructive airway disease have hypoxemia only. Chronic respiratory acidosis is usually seen in patients with chronic bronchitis alone or as the predominant disease in combined bronchitis

---

Doctor Sackner is chief, Division of Pulmonary Disease, Mt. Sinai Hospital, Miami Beach. His article is one in a series on clinical cardiology prepared by the American Heart Association and made available to **Michigan Medicine** through the Michigan Heart Association.

and emphysema. Acute respiratory acidosis may occur in patients with pre-existing pulmonary diseases who have superimposed infections, retained secretions, narcotic dosage or overdosage, congestive heart failure, status asthmaticus or pneumothorax. Metabolic acidosis may complicate acute respiratory acidosis in conditions such as status asthmaticus and pulmonary edema.

A chest roentgenogram should always be obtained in patients with pulmonary emphysema who develop acute pulmonary insufficiency. In these patients, pneumothorax and pneumonitis may give few or no physical signs. An electrocardiogram should be obtained routinely since cardiac arrhythmias are frequent. A gram stain of the sputum smear should be examined immediately to help in the choice of an antibiotic.

In terms of management, we have found the following classification of pulmonary insufficiency useful. It is based on 1) the state of the sensorium, 2) obstructive airway signs, 3) signs of retained secretions and 4) acid-base balance as estimated by arterial blood gas analysis.

Alert; Obstructive Airway Signs; No Co_2 Retention This is probably the commonest type of pulmonary insufficiency. It is found in status asthmaticus and in anxiety reactions in patients with pre-existing pulmonary diseases. Hypoxemia and respiratory alkalosis are generally present. Psychotherapy is by far the most important mode of treatment. The physician must repeatedly assure the patient that breathlessness will decrease if respirations are slowed and if he relaxes. The physician must remain in the patient's presence and give vocal encouragement until this is accomplished. In addition, but not as a substitute, intermittent positive pressure breathing using slow respiratory flow rates and nebulizing 4-8 drops of racemic epinephrine in 5ml IV aminophyllin solution for 15 minutes every 3 hours may be useful. If psychotherapy is ineffective, sedation must be employed using mild tranquilizers to narcotics as indicated. Intravenous steroid and aminophyllin therapy are often beneficial. If there is coexisting metabolic acidosis as in status asthmaticus, initially 1 ampule of $NaHCO_3$ (44.5meq) should be given for every -4 to -5 meq of base excess and further requirements followed by serial arterial blood gas determinations.

Alert; Obstructive Airways Signs; Acute Respiratory Acidosis This condition develops in certain patients with status asthmaticus, in patients with emphysema and/or chronic bronchitis who develop a bronchopulmonary infection or anxiety reaction. These patients frequently show rapid shallow respirations and hold their chests in a high inspiratory position. Reassurance should be employed but is not as effective as in those patients without CO_2 retention. These patients should be treated with intermittent positive pressure breathing until arterial pCO_2 returns to normal. If bronchospasm exists, intravenous steroids and aminophyllin should be employed. Narcotics and sedation are usually contraindicated because of their depressant effects on the respiratory center. However, if the tachypnea persists and if intermittent positive pressure breathing is fought by the patient, then a trial of sedation may be indicated. This type of treatment should only be utilized if the patient is in an intensive care unit under close medical surveillance and if intubation equipment is immediately available with close monitoring of arterial blood gases. Base deficits should be corrected with intravenous sodium bicarbonate.

Alert; Retained Secretions; No CO_2 Retention Representative examples in this category include pneumonitis, post-operative atelectasis and acute exacerbations of chronic bronchitis or bronchiectasis. The best results in terms of removal of secretions are obtained with chest physiotherapy. A trained chest physiotherapist performs shaking and clapping of the chest and postural drainage, and educates the patient in correct coughing. Nasotracheal suction should always be done initially by an experienced attending physician before turning this task over to nursing since it is often difficult to carry out properly. Deep breathing exercises and intermittent positive pressure breathing should be used in atelectasis. Heated aerosol is indicated for loosening secretions in large airways, the ultrasonic nebulizer for small airways. Antibiotics should be administered if the sputum is purulent. Provided the patient remains alert, bronchoscopy is usually not required.

Alert; Obstructive Airway Signs; Chronic Respiratory Acidosis Patients with chronic bronchitis and/or emphysema may show this condition. The blood pH is near normal, pCO_2 and base excess elevated and hypoxemia is present. If arterial pCO_2 is less than 62 mm Hg with near normal pH, these patients should be maintained on intermittent positive pressure breathing four times a day, or as necessary, at home or in the hospital. Arterial pCO_2 above 62 mm Hg represents an unstable condition; the patient may become acutely acidotic with minimal stresses. These patients should be hospitalized and given hourly or two hourly treatments with intermittent positive pressure breathing until pCO_2 falls below 62 mm Hg. Measures must be taken to keep pH normal by correcting the co-existing compensating metabolic alkalosis with saline, ammonium chloride, potassium chloride, arginine hydrochloride or diamox as dictated by cardiac, renal and electrolyte considerations. The goal in therapy is to keep pCO_2 below 62 mm Hg while keeping blood pH normal during room air breathing; it is not to bring pCO_2 down to a normal value of 40 mm Hg. It is important to ventilate these patients with oxygen concentrations not greater than 30% because respiratory center depression may occur immediately after a treatment with the respirator if higher oxygen concentrations are used. As in other patients with obstructive airway signs intravenous steroids and aminophyllin, chest physiotherapy and nasotracheal suction are useful adjuncts. This group of patients also frequently has incipient grades of congestive heart failure. Digitalis and diuretic therapy added to regimen occasionally bring pCO_2 to normal and partially relieve the hypoxemia.

Stupor; Acute Respiratory Acidosis This condition is most likely to occur in patients with obstructive airway disease who have been given sedation, or develop an acute bronchopulmonary infection or have incomplete elimination or anesthetics or neuromuscular agents following surgery. These patients should be treated with continuous intermittent positive pressure breathing until pCO_2 returns to normal. A volume limited respirator with a mask is preferred since leaks can be overcome by increasing the volume delivered by the machine, whereas pressure limited respirators do not cycle well if inflation pressures greater than 25 cm water need to be employed. If the latter occurs and a volume limited respirator is unavailable, then intubation with a cuffed endotracheal tube should be carried out. Bedside bronchoscopy is useful. Tracheostomy should be considered if there are copious secretions and if the patient cannot be taken off the endotracheal tube after 96 hours. Since gastric ileus occurs in many of these cases, the gastric contents should be emptied by a nasogastric tube.

Stupor; Obstructive Airway Signs; Acute and Chronic Respiratory Acidosis These patients are best treated by continuous controlled ventilation by a mask using a volume-limited respirator. This can also be handled with a pressure limited respirator but one must be prepared to do more frequent monitoring of arterial blood gases and ventilation. However, intubation is usually necessary when the latter type of respirator is employed. The goal of therapy is to reach a normal pH over a 6-24 hour period, *not a normal* pCO_2. Rapid correction of arterial pCO_2 to normal levels with alkaline pH in these patients is associated with a fatal encephalopathy. Adjunctive therapy includes chloride replacement or bicarbonate diuresis, antibiotics, nasogastric suction and diuretics. If secretions are thick and copious and a tracheostomy employed, lung lavage should be done every 4 hours with a 5ml. solution of equal parts of intravenous $NaHCO_3$ solution and saline.

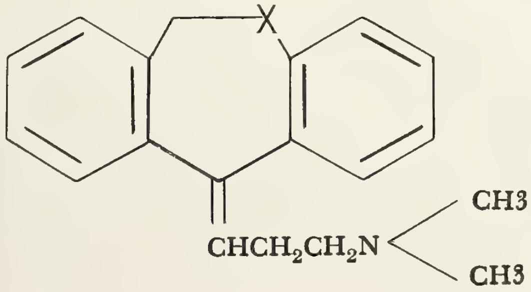
Coma; Respiratory Acidosis These patients should be bronchoscoped at the bedside, secretions removed and a cuffed endotracheal tube inserted. They should be placed on continuous controlled ventilation with a volume limited respirator. The goal of therapy is restoration of normal pH. Depending upon the base excess, replacement of chloride or bicarbonate should be carried out. Nasogastric suction, antibiotics, diuretics and tracheostomy are useful adjunctive measures.

Correction:

In the September issue of *Michigan Medicine*, in a scientific article entitled "New Drug Information," an error occurred in the chemical description of the new drug, Doxepin HCl.

The paragraph should have appeared as follows:

"Doxepin HCl is N, N-Dimethyl-dibenz (b,e) oxepin-$\Delta^{11(6H)}$, γ propylamine hydrochloride. It is quite similar to the tricyclic derivatives chemically and pharmacologically. Doxepin differs from amitriptyline only by having an oxygen in place of a CH_2 group in the 7 membered meso ring at position 11:



X=CH_2 (Amitriptyline)

X=O (Doxepin)

• HCl

"Doxepin is a stable, white crystalline solid, soluble in water, lower alcohols and chloroform, and sensitive to light. Stability studies at 25 degrees and 37 degrees C show doxepin to be stable requiring no expiration date."

Drug And Therapy Problems

By Robert E. Pearson, M.S.
Persis Mehta, Ph.D.
Ann Arbor

Q. Does Live Mumps Virus Vaccine affect the tuberculin skin test? (S.M., Ypsilanti)

A. Recent studies have shown that there is a significant depression of hypersensivity to tuberculin, following the administration of live attenuated mumps virus vaccine. This phenomenon is observed in both susceptible seronegative children and seropositive, presumably immune, children. Sensitivity is further suppressed by repeated tuberculin testing. A possible explanation for the delayed hypersensitivity is that the mumps virus, by interaction with the cytoplasmic membrane of lymphocytes, may decrease the ability of the immunoreactive lymphocyte to respond to the tuberculo protein antigen.

Q. What is the effect of sodium fluoride treatment in osteoporosis? (M.M., Detroit)

A. Although the use of sodium fluoride in the treatment of this particular condition is still in the investigational stages, there have been several reports demonstrating its efficacy as a therapeutic agent. The fluoride appears to act by the stimulation of the osteoblasts, resulting in formation of new bone tissue. Normal mineralization of the tissue leading to new bone formation occurs when the intake of calcium and Vitamin D is increased. At the present time, it appears that treatment rather than prevention is the more practical approach to osteoporosis.

Q. Has Vitamin E been used for leg cramps? (H.G., Detroit)

A. A recent investigation into the therapeutic effects of Vitamin E (d-alpha-tocopherol acetate) revealed that this compound produced prompt relief in patients suffering from leg cramps (Systremma) and the "restless legs" syndrome. The average adult dose is 100 i.u. three times a day before meals. Relief was found to occur within a week or two.

Q. Is Congo Red dye carcinogenic? (L.M., Garden City)

A. There has been no clinical evidence confirming the carcinogenicity of this dye. Theoretically there is, however, the possibility that Congo Red may cause tumors when administered orally. It is believed that the bacteria in the gut cause a split in the azo linkages of the dye, thus releasing free benzidine, which is known to cause tumors in the bladder.

Mr. Pearson is Director and Dr. Mehta is Associate Project Coordinator of the Michigan Regional Drug Information Center, Hospital Pharmacy, University Hospital, Ann Arbor 48104.

Here is Procedure For Donating Body To Medical Research

MSMS is receiving more and more requests from physicians and citizens asking "how does one go about donating his body to medical research?"

The following information is provided in reply:

In 1969 the Michigan State Legislature enacted Public Act 189, known as the "Uniform Anatomical Gift Act" which states:

> "Any individual of sound mind and 18 years of age or more may give all or any part of his body for any purposes specified in section 4, the gift to take effect upon death."

The act also called for a uniform donor card to be circulated throughout the state. To date the Attorney General has not decided on the language to be used and a uniform card does not exist.

Presently, a person wishing to donate all or part of his body may specify so in his will or he may contact the Michigan Anatomy Committee which consists of the State Health Commissioner, and two members from each Department of Anatomy of the medical schools of the state. A donor will be given a form for the educational institution to which he wishes to make the donation and an example of the Wayne State University form is attached.

Requests for donor cards can be made by telephoning the school to which the individual wishes to make the donation:

Wayne State University Nicholas J. Mizers, Ph.D.	(days) 313/577-1188 (nights) 313/577-1198
Universty of Michigan Thomas M. Oelrich, Ph.D.	313/764-4359
Michigan State University Rexford E. Carrow, Ph.D.	517/353-4533

Hypotension And the Shock Syndrome

By Richard S. Ross, M.D.
Baltimore

Hypotension is a common and often benign consequence of myocardial infarction while the "shock syndrome" is a less common, but often fatal complication. Precise definition and clear understanding of the hemodynamic consequences of myocardial infarction are, therefore, necessary for management.

Blood pressure alone is not a good index of the patient's clinical status. Blood pressure (BP) is a function of both cardiac output (CO) and total peripheral resistance (TPR) as indicated by the simple relationship:

$$BP = CO \times TPR$$

Thus, BP will be reduced if either CO or TPR are reduced.

Shillingford and colleagues have shown that there are two physiological patterns associated with arterial hypotension depending upon the state of peripheral resistance. In one group of patients, the hypotension is clearly related to a reduced cardiac output and the peripheral resistance may be normal or increased. In the second group, TPR is reduced but the cardiac output is normal. These two groups can sometimes be distinguished clinically. The first group with increased resistance presents with cool extremities and a small pulse volume while the second group is characterized by warm extremities and a full pulse.

Hypotension exists in at least 80% of patients following myocardial infarction and in most patients the blood pressure will return to normal levels with the relief of pain and the administration of oxygen. The hypotension occasionally persists for weeks or months, but is often unassociated with significant symptoms.

The Shock Syndrome

The shock syndrome occurs in about 20% of patients with myocardial infarction and accounts for at least 50% of the deaths now that the mortality from arrhythmias has been reduced. The mortality rate in patients with the shock syndrome secondary to myocardial infarction ranges from 85 to 95% if the syndrome is rigidly defined and clearly distinguished from simple hypotension as described above.

The following criteria for the shock syndrome define a population of patients with a mortality of greater than 95%. 1) Systolic arterial blood pressure of less than 80 mm.Hg, 2) Clinical signs of peripheral circulatory insufficiency; cold, moist skin and cyanosis, 3) Dulled sensorium, 4) Oliguria with urine flow of less than 30 ml/hr, and 5) Failure of improvement to follow relief of pain and the administration of oxygen.

The insult to the heart is the cause of the shock syndrome in myocardial infarction although all organ systems are ultimately involved. The function of the heart is impaired by the initial insult and this results in a decrease in arterial pressure and, hence, coronary blood flow because of its dependence upon aortic perfusion pressure.

The reduction in coronary perfusion pressure and myocardial blood flow further impairs myocardial function and may increase the size of the myocardial infarction. Arrhythmias and metabolic acidosis also participate in this deterioration in that they are the result of inadequate perfusion and both tend to perpetuate the precipitating conditions.

It is this negative feedback relationship (impaired cardiac function — arterial hypotension — reduced coronary blood flow — impaired cardiac function) which accounts for the high mortality associated with the shock syndrome.

Cardiac output is lower in a population of patients with shock than in those who do not have the shock syndrome, but this is by no means the whole explanation. There are many patients with myocardial infarction without shock who have cardiac outputs in the same range or lower than those measured in patients with shock and, therefore, it is not possible to characterize these patients on the basis of changes of cardiac output alone.

The author is professor of medicine and director of the Cardiovascular Division, Department of Medicine, The Johns Hopkins University School of Medicine. His paper is another in the series on clinical cardiology prepared by the American Heart Association and made available o **Michigan Medicine** by the Michigan Heart Association.

Total peripheral resistance, the other factor important in determining blood pressure, may be either normal, increased, or decreased in myocardial infarction. Here again, a similar range of values for total peripheral resistance can be seen in patients in the absence of shock.

Normally, a fall in cardiac output is accompanied by a compensatory rise in total peripheral resistance, but in patients with shock due to myocardial infarction the appropriate response in peripheral resistance fails to occur.

Thus, it appears that the total peripheral resistance is inadequate to support blood pressure at the existing level of cardiac output, regardless of the extent of reduction of the latter.

Treatment

The objective of treatment is the interruption of the negative feed back loop whereby impaired myocardial function leads to a reduction in arterial pressure, decreased coronary blood flow and a further depression of left ventricular function. This objective is approached by attempting to improve cardiac function and to raise the arterial blood pressure.

Vasopressors constitute an important form of therapy for shock of myocardial infarction. A small increase in arterial pressure may result in a sizable increase in coronary blood flow. The best vasopressors for use in myocardial infarction are nor-epinephrine (Levophed) and metaraminol (Aramine) which act both on the alpha receptors in the arterial wall and also on the beta receptors in the myocardium.

Thus, the practical experience with the treatment of shock in myocardial infarction is consistent with the theory of pathogenesis which emphasizes the dual nature of the pathophysiology in that drugs which act on both the heart and the peripheral circulation are the most effective.

Consideration of the central role of impaired myocardial function in the shock syndrome leads to the conclusion that cardiac glycosides should be administered to all patients with this condition. Obviously, the cardiac glycosides cannot improve the function of necrotic myocardium, but a positive inotropic influence of the non-infarcted myocardium is desirable. It has been demonstrated that the incidence of arrhythmia and cardiac rupture is no higher in patients with myocardial infarction treated with digitalis than in a control group.

Certain general measures have proven useful in the treatment of the shock syndrome. All patients with the shock syndrome should receive 100% oxygen continuously because the addition of dissolved oxygen to the plasma helps to combat the hypoxemia which is universally present.

The relief of pain is important as some vasodepressor reflex activity may be a response to severe pain, but narcotics should be used cautiously in view of their hemodynamic effects. Fluid volume replacement has a limited, but definite, place in the therapy of the shock syndrome due to myocardial infarction. It may be indicated in patients who have been receiving pressor drugs for a prolonged period because pressor therapy results in a decrease in plasma volume secondary to the movement of fluid into extravascular space. In such patients, if central venous pressure is low and there is no evidence of pulmonary congestion, the blood pressure may be easier to maintain after plasma volume has been expanded by the administration of plasma or salt poor albumin.

Venous pressure should be monitored and the lungs examined frequently during the administration of plasma. Also, fluid replacement is necessary in patients who have lost extracellular fluid volume consequent to vomiting or sweating.

The high mortality and relative ineffectiveness of conventional therapy has provided the stimulus for the investigation of other approaches to the problem.

The basic defect in the shock syndrome is impaired myocardial function and, therefore, many mechanical assist devices are currently under investigation. The therapeutic value of hyperbaric oxygen therapy is also under study. Studies with experimental animals are encouraging, but clinical trials have been disappointing.

A large fraction of patients with the shock syndrome have severe, diffuse coronary atherosclerosis with large areas of infarcted myocardium. It is in this group of patients that total replacement of the heart by a homo-transplant or an artificial device will have its greatest potential usefulness. Circulatory assist devices may have their greatest use in sustaining life until this is possible.

Correction . . .

In a scientific article entitled "Air Embolism Following Open Heart Surgery: A Preventable Cause of Death," which appeared in the September issue of *Michigan Medicine,* an error occurred in the number of cases reported under study.

Walter H. Janke, M.D., and Ali A. Esfahani, M.D., Flint, authors of the article, wish to correct the number of total cases studied, which appear as 113, 133 and 110 in the article, to 133 in all cases.

Perinatal Tips

The following cases from the files of the Wayne County Medical Society Perinatal Mortality Committee are presented as an aid in continuing education.

By Paul M. Zavell, M.D.
Detroit

Case One

Maternal

This was a 33-year-old blood Rh negative white mother in her fifth pregnancy. Her frst three pregnancies were uneventful with three living healthy children at home. Her fourth pregnancy three years earlier resulted in a macerated stillbirth at 38 weeks (placenta "consistent with erythroblastosis fetalis"). For this fifth pregnancy her weight gain in 37 weeks was 26 pounds. No blood studies were done on the mother, despite three prenatal visits beginning at the fifth month. From these visits we only learned the following: Blood Pressure ranged 130-148/80-90 with +1 pedal edema at her last visit one week before delivery. No albumin in the urine was noted. Her hemoglobin on one occasion was 10.0 gm and her VDRL was negative. At 37 weeks labor began. First stage was 21 hours 10 minutes, second stage was 4 hours 53 minutes and third stage was 1 minute.

Fetal

An 8 lb. 3 oz. hydropic infant born by low forceps. This infant took one breath and then expired despite prolonged resuscitation efforts. Cord Blood was B+, Coombs 3+ and Bilirubin of 3.7 mgm percent. Placenta was very large, edematous and "consistent with erythroblastosis fetalis."

Doctor's Explanation

These parents were poor and the mother unreliable in her prenatal visits.

Perinatal Committee Comments

1. Any Rh negative mother (especially a multipara) should have serial titer studies during pregnancy.

2. An Rh negative multipara with a history of a stillbirth infant should alert the doctor to very likely trouble in future pregnancies.

3. Where there is actual (or probable) iso-immunization present, amniocentesis studies (and possible intra-uterine transfusions) should be performed. Appropriate centers are readily available with today's excellent means of communication.

4. Whenever a probable Rh iso-immunization is imminent, the doctor handling the infant should be alerted by the delivering doctor in enough time to arrange beforehand for appropriate care at birth (for example, blood for exchange).

5. If an infant is transferred from one hospital to another for evaluation or treatment, at least 10 cc size sample of the mother's blood should accompany the infant (to save time and to simplify proper treatment).

6. The fact that a pregnant mother is poor or unreliable in keeping her prenatal visits places more responsibility on the attending doctor to use all his resourcefulness, persuasiveness, ingenuity and compassion to avoid the result achieved here.

Case Two

MATERNAL:

This was the eighth born of 35 year old A+ white mother. All her prior deliveries were vaginal, 40 weeks duration and resulted in normal living children. Her present pregnancy was characterized by painless vaginal bleeding from 27 weeks on due to placenta previa. She was hospitalized and received twelve pints of blood before a C-Section at 32 weeks. Her post operative course was uneventful.

FETAL:

A 2 lb. 11 oz. white male infant lethargic and grunting was born. The apgar score was 8 after C-Section. The infant was placed in an isolette with oxygen and mist but in a few hours this was canceled because of no difficulties. The infant was given no nourishment for the first 24 hours and then he was put on Karo water by nipple. This was taken poorly. On second day of life he was put on half strength 60-40 Similac but he sucked very poorly. On 3rd, 4th and 5th days of life 8 cc of saline daily was given subcutaneously. On the 5th day of life his hemoglobin was 23.6 gm with 14.6 mgm % Bilirubin. On the 8th day of life Bilirubin was 13.1 mgm %. The nurses' notes repeatedly remark of "dehydration" and "sucking poorly." However, he was kept on above formula despite this with no other fluid given. On the 15th day of life he looked especially bad and lethargic when bloody stools suddenly began. Two hours later he died. Post mortem exam showed acute

---

Doctor Zavell is chairman, Neo-Natal and Hospital Care Committee, Michigan Chapter, A.A.P., and chairman, Perinatal Mortality Study Committee, Wayne County Medical Society.

hemorrhagic enterocolitis in a badly dehydrated and jaundiced premature infant.

PERINATAL COMMITTEE COMMENTS:

1. The heroic method by the obstetrician to deliver a good viable infant was commended.

2. Small infants who can't suck well can and should be carefully gavaged. There is little excuse to wait 24 hours to start feeding (4 to 8 hours after birth are more acceptable).

3. Clyses in infants are rarely useful. Even very small infants can be fed by I.V. fluid (scalp, umbilical, hand, etc.).

4. Jaundice of the premature can be favorably treated both with fluid (oral or I.V.) and the Bilirubin light if exchange transfusion is not warranted.

5. Very small infants such as this one require close teamwork and almost constant attention. This is best accomplished in an infant intensive care unit at some large medical center (if one is not immediately available in the hospital of birth).

MICHIGAN
DEPARTMENT
OF PUBLIC
HEALTH

Monthly Surveillance Report

Cases of Certain Diseases Reported To The Michigan Department of Public Health For the Four-Week Period Ending October 30, 1970

	1970 This 4-Week Period	1969 Same 4-Week Period	1970 Total To Above Date	1969 Total Same Date	Total Cases for 1969
Rubella	79	122	2,779	3,947	4,307
Congenital Rubella Syndrome	—	—	—	—	—
Measles	39	26	1,764	321	401
Whooping Cough	27	25	180	153	192
Diphtheria	—	—	—	—	—
Mumps					
Scarlet Fever &	398	238	5,457	4,242	5,215
Strep Sore Throat	686	598	9,307	7,457	9,763
Tetanus	2	0	6	4	6
Poliomyelitis (paralytic)	0	0	1	0	0
Hepatitis	347	304	3,822	2,685	3,360
Salmonellosis (other than S. typhi)	45	38	545	450	539
Typhoid Fever (S. typhi)	1	1	12	5	6
Shigellosis	23	31	174	251	300
Aseptic Meningitis	54	27	263	143	179
Encephalitis	26	11	134	106	120
Meningococcic Meningitis	6	4	61	97	114
H. Influenza Meningitis	2	2	39	46	56
Tuberculosis	169	180	1,701	1,801	2,108
Syphilis	358	268	3,240	3,467	4,021
Gonorrhea	1,648	1,858	17,422	16,196	19,194

Information can be supplied by the local health department on the local incidence of disease.

Maurice Reizen, M.D., Director
Michigan Department of Public Health

Campbell's Soups...
wide variety...for limited appetites

Many people lose interest in food as they grow older. Some of them are fussy eaters—with only a few favorite foods. Others become indifferent to foods—because planning and preparing meals becomes a chore. Here Campbell's Soups can help—for these four very good reasons:

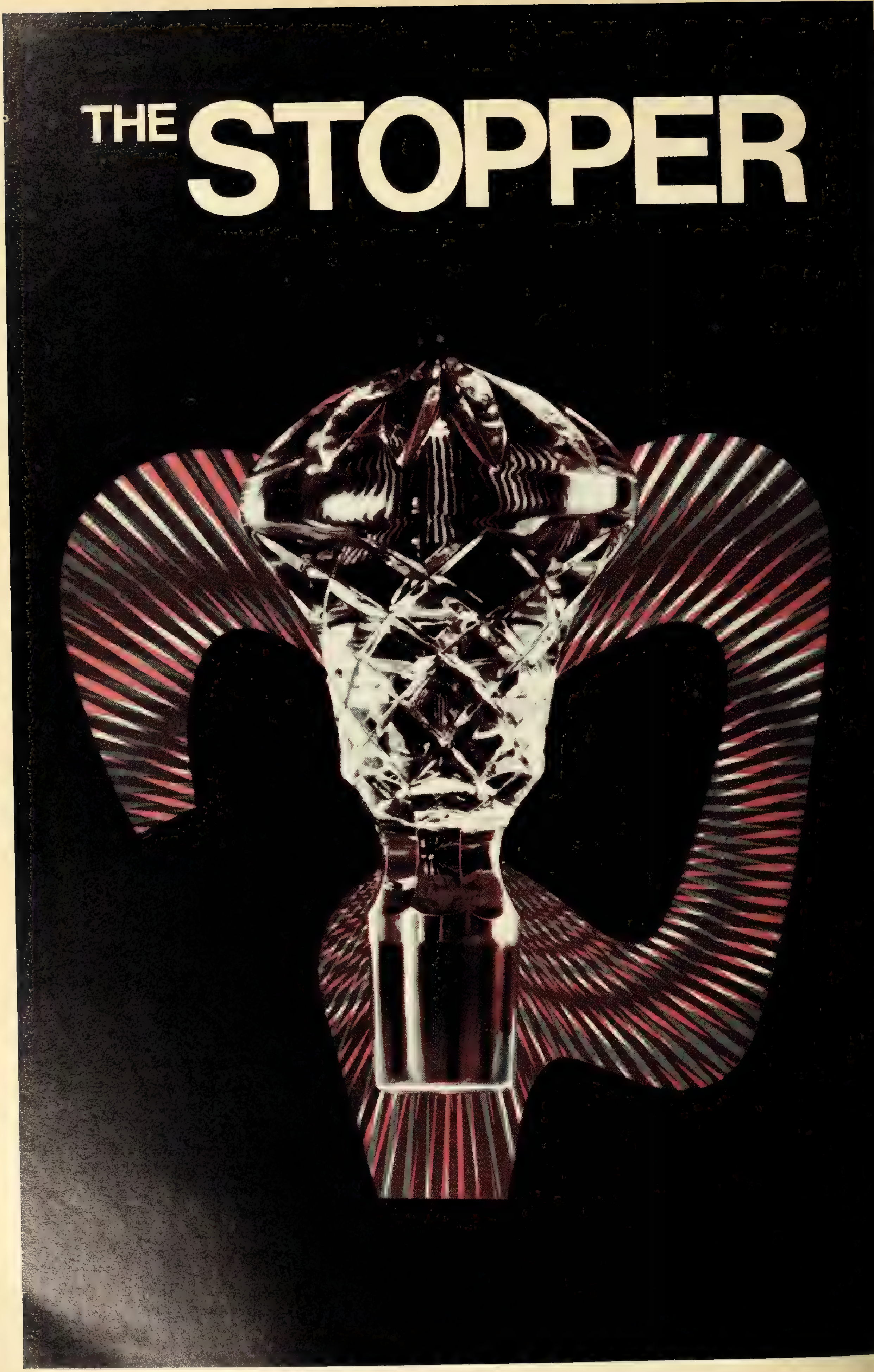
Appeal With a variety of tastes, textures, aromas, and colors, Campbell's Soups can add interest and appetite appeal. And they're easy to eat—ingredients are tender, bite-size. Even patients on special diets will find soups they can enjoy among the more than 50 different varieties available.

Nourishment Campbell's Soups contain selected meats and sea foods, best garden vegetables—carefully processed to help retain their natural flavors and nutritive values.

Convenience Within 4 minutes a bowl of delicious soup is heated and ready to eat.

Economy Campbell's Soups are inexpensive—an important consideration to those whose budgets are limited.

Recommend Campbell's Soups . . . and, of course, enjoy them yourself. Remember, *there's a soup for almost every patient and diet . . . and for every meal.*


THE STOPPER

LOMOTIL®

tablets/liquid

Each tablet and each 5 cc. of liquid contain:
diphenoxylate hydrochloride ....2.5 mg.
(Warning: May be habit forming)
atropine sulfate ....0.025 mg.

first aid in diarrhea of acute gastroenteritis

PROMPT ANTIDIARRHEAL ACTION

Roentgenographic studies demonstrate that the motility-lowering activity of Lomotil is concentrated in the first three hours and continues for at least six hours.

Clinical investigators have found ample confirmation of these determinations. Lomotil has reduced diarrheal urgency in many patients within one hour.

OPTIMAL ANTIDIARRHEAL CONTROL

Numerous investigators have remarked on the high degree of effectiveness of Lomotil in a variety of diarrheal disorders. Lomotil has given good to excellent relief of symptoms in many patients who had failed to respond to other measures.

UNSURPASSED ANTIDIARRHEAL ACCEPTANCE

Patients prefer Lomotil for its convenience, its prompt control of diarrhea and its relief of cramping and urgency. Physicians specify Lomotil for its dependable action and its relative freedom from side effects when taken as directed.

Warnings: Lomotil should be used with caution in patients taking barbiturates and, if not contraindicated, in patients with cirrhosis, advanced liver disease or impaired liver function.

Precautions: Lomotil is a federally exempt narcotic with theoretically possible addictive potential at high dosage; this is not ordinarily a clinical problem. Use Lomotil with considerable caution in patients receiving addicting drugs. Recommended dosages should not be exceeded, and medication should be kept out of reach of children. Signs of accidental overdosage may include severe respiratory depression, flushing, lethargy or coma, hypotonic reflexes, nystagmus, pinpoint pupils, tachycardia; continuous observation is necessary. The subtherapeutic amount of atropine sulfate is added to discourage deliberate overdosage.

Adverse Reactions: Side effects reported with Lomotil therapy include nausea, sedation, dizziness, vomiting, pruritus, restlessness, abdominal discomfort, headache, angioneurotic edema, giant urticaria, lethargy, anorexia, numbness of the extremities, atropine effects, swelling of the gums, euphoria, depression and malaise.

Overdosage: The medication should be kept out of reach of children since accidental overdosage may cause severe, even fatal, respiratory depression.

Dosage: The recommended initial daily dosages, given in divided doses until diarrhea is controlled, are as follows:

Children:
3-6 mo. .. ½ tsp.* t.i.d. (3 mg.)
6-12 mo. .. ½ tsp. q.i.d. (4 mg.)
1-2 yr. ... ½ tsp. 5 times daily (5 mg.)
2-5 yr. ... 1 tsp. t.i.d. (6 mg.)
5-8 yr. ... 1 tsp. q.i.d. (8 mg.)
8-12 yr. .. 1 tsp. 5 times daily (10 mg.)
Adults: ... 2 tsp. 5 times daily (20 mg.)
or 2 tablets q.i.d.
*Based on 4 cc. per teaspoonful.

Use of Lomotil is not recommended in infants less than 3 months of age.

Maintenance dosage may be as low as one-fourth the initial daily dosage.

953

G. D. SEARLE & CO. • P.O. Box 5110, Chicago, Illinois 60680 • Research in the Service of Medicine

in cardiac edema

Dyazide®

Trademark

Each capsule contains 50 mg. of Dyrenium® (brand of triamterene) and 25 mg. of hydrochlorothiazide.

gets the water out

spares the potassium

Before prescribing, see complete prescribing information in SK&F literature or *PDR*.

Indications: Edema associated with congestive heart failure, cirrhosis of the liver, the nephrotic syndrome, late pregnancy; also steroid-induced and idiopathic edema, and edema resistant to other diuretic therapy. 'Dyazide' is also indicated in the treatment of mild to moderate hypertension.

Contraindications: Pre-existing elevated serum potassium. Hypersensitivity to either component. Continued use in progressive renal or hepatic dysfunction or developing hyperkalemia.

Warnings: **Do not use dietary potassium supplements or potassium salts unless hypokalemia develops or dietary potassium intake is markedly impaired.** Enteric-coated potassium salts may cause small bowel stenosis with or without ulceration. Hyperkalemia ($>$5.4 mEq/L) has been reported in 4% of patients under 60 years, in 12% of patients over 60 years, and in less than 8% of patients overall. Rarely, cases have been associated with cardiac irregularities. Accordingly, **check serum potassium during therapy, particularly in patients with suspected or confirmed renal insufficiency (e.g., certain elderly or diabetics). If hyperkalemia develops, substitute a thiazide alone. If spironolactone is used concomitantly with 'Dyazide', check serum potassium frequently**—they can both cause potassium retention and sometimes hyperkalemia. Two deaths have been reported in patients on such combined therapy (in one, recommended dosage was exceeded; in the other, serum electrolytes were not properly monitored). Observe regularly for possible blood dyscrasias, liver damage or other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving Dyrenium (triamterene, SK&F). Rarely, leukopenia, thrombocytopenia, agranulocytosis, and aplastic anemia have been reported with the thiazides. Watch for signs of impending coma in acutely ill cirrhotics. Thiazides are reported to cross the placental barrier and appear in breast milk. This may result in fetal or neonatal hyperbilirubinemia, thrombocytopenia, altered carbohydrate metabolism and possibly other adverse reactions that have occurred in the adult. When used during pregnancy or in women who might bear children, weigh potential benefits against possible hazards to fetus.

Precautions: Do periodic serum electrolyte and BUN determinations. Do periodic hematologic studies in cirrhotics with splenomegaly. Antihypertensive effects may be enhanced in postsympathectomy patients. The following may occur: hyperuricemia and gout, reversible nitrogen retention, decreasing alkali reserve with possible metabolic acidosis, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), digitalis intoxication (in hypokalemia). Use cautiously in surgical patients. Concomitant use with antihypertensive agents may result in an additive hypotensive effect.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis; rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting (may indicate electrolyte imbalance), diarrhea, constipation, other gastrointestinal disturbances. Rarely, necrotizing vasculitis, paresthesias, icterus, pancreatitis, and xanthopsia have occurred with thiazides alone.

Supplied: Bottles of 100 capsules.

SK&F

Smith Kline & French Laboratories

MATERNAL HEALTH DESK REFERENCE CARD NO. 13

(Sponsored and Prepared by the Committee on Maternal and Perinatal Health,
Michigan State Medical Society)

The Low Birth Weight Infant

**Note*: In some instances premature labor may be stopped by the carefully monitored use of isoxsuprine ("vasodilan")[1] or intravenous, alcohol.[2] This is contraindicated if membranes are ruptured.

REFERENCES

1. Hendricks, Charles H., "The Use of Isoxsuprine for the Arrest of Premature Labor," *Clinical OB-GYN* 7:687, 1964.
2. Fuchs, Fritz, et. al. "Effect of Alcohol on Threatened Premature Labor," *American Journal of Obstetrics and Gynecology*, 99:627, 1967.

Infants with a birth weight of 2,500 gm. (5½ lbs.) or less are classified as Low Birth Weight Infants. The 8% of live births in this group pose the greatest challenge to Obstetrics and Pediatrics today and the incidence of such births is rising steadily. These infants have a neonatal mortality rate 35 times greater than other babies: currently 75% of neonatal deaths and 50% of infant deaths come from this group. Surviving low birth weight infants face a five-fold increased risk of cerebral palsy and a doubled risk of mental retardation or other C.N.S. problem.

The low birth weight infant may result from pre-term delivery or be small at term from intrauterine growth retardation. Gestational age is probably a more important prognostic factor than birth weight but dates are often difficult to assess.

PREVENTION

In the majority of instances the direct cause of low birth weight infants cannot be identified. Approximately a third of such deliveries are due to medical or obstetrical complications of pregnancy and about 12% result from multiple pregnancy (twins, triplets, etc.). In the absence of a known cause specific preventive measures are usually not possible.

Patients at maximal risk of delivering a low birth weight infant may frequently be identified. Women with a history of such a delivery or of a neonatal or fetal death face more than a doubled risk of delivering a low birth weight infant in subsequent pregnancy. Chronic medical conditions including renal disease, hypertension and heart disease increase the risk of such outcome of pregnancy as does maternal Rubella during gestation. Obstetrical factors such as toxemia, abruptio placentae or placenta previa may result in premature labor, retarded intrauterine growth or may compel intervention and delivery before term. Babies with congenital anomalies tend to be small and abnormalities of the maternal generative tract including septate uterus and incompetent cervix may also result in low birth weight infants.

It is known that socio-economic influences play a significant role in the incidence of low birth weight infants. A combination of factors including poverty, inadequate nutrition, low education, crowded homes, maternal fatigue, poor hygiene, successions of closely spaced pregnancies, extremes of maternal age or parity, and illegitimacy are all identified as increasing the risk of delivering a low birth weight infant.

High risk patients require intensified prenatal care. Although specific preventive measures are not known, good medical care, adequate nutrition and rest appear to reduce the incidence of low birth weight infants. In multiple pregnancy bed rest is particularly useful especially from the 32nd to the 36th week of gestation. Hospitalization is usually not necessary.

When elective induction or Cesarean section is to be performed gestational age should be known accurately enough to avoid the tragedy of delivering a preterm infant. Meticulous attention to the milestones of uterine growth and fetal development in early pregnancy (prior to the 20th week) are a requirement of adequate prenatal care. Uterine size must be compared to gestational dates at time of the pelvic exam required at first visit. At subsequent visits its growth into the abdomen must also be evaluated and notation made of its compatibility with weeks of gestation. The calendar date when quickening was felt and the fetal heart first heard must also be stated in the chart for comparison against gestational date. In the last trimester of pregnancy it is good practice to make a written estimate of fetal weight (E.F.W.) at each visit: only by practice may this guessing game acquire a semblance of accuracy! Where doubt exists about pregnancy dates, special measures including fetal X-ray, amniotic fluid analysis or ultrasound cephalometry are required to confirm fetal maturity. Otherwise the onset of spontaneous labor should be awaited.

CARF DURING LABOR

In the absence of clearly identified preventive measures the main thrust of avoiding mortality and morbidity hinges upon intensive care in labor, delivery and the immediate neonatal period.*

During labor patients with an anticipated low birth weight infant should be followed with particular care. All respiratory depressing drugs including narcotics and sedatives should be avoided. If analgesia is needed prior to delivery continuous epidural (or caudal) or paracervical block anesthesia may be used. For delivery, conduction anesthesia or pudendal block are preferred. General anesthesia should be avoided.

DELIVERY

During delivery the low birth weight infant faces maximal risk of trauma. The softness of the skull and the fragility of cerebral vessels increase the hazard of intracranial hemorrhage: vessel fragility is further increased by anoxia and a vicious cycle of trauma, anoxia and intracranial hemorrhage may occur. To protect the vulnerable fetal head during delivery a large episiotomy should be made: this prevents compression during crowning and rapid decompression upon expulsion. Outlet forceps may be used to cradle and protect the soft fetal skull but traction and mid-forceps delivery should be avoided.

Resuscitation may be necessary: it is imperative to have skilled personnel available so that intubation and positive pressure respiration may be initiated at once if the baby is depressed. When the baby is breathing spontaneously it should be placed in an incubator: all Obstetric Units should have a pre-warmed incubator constantly available in the delivery area in anticipation of such deliveries. The Pediatrician and neonatal nursery should be warned of the impending delivery of such a vulnerable infant.

NEONATAL CARE

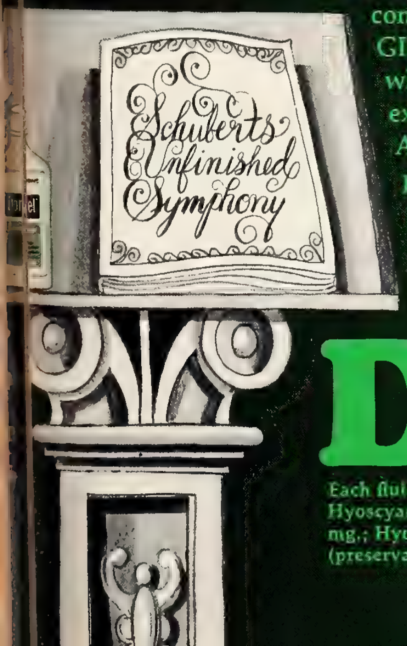
The neonatal care of the low birth weight infant requires skilled pediatric medical and nursing care. It is essential that adequate consultation is available in all nurseries for the continued care of such high risk infants.

Jan Schneider, M.D.
December, 1970

The concert was just underway,
When to the conductor's dismay
Cramps and diarrhea,
Did so quickly appear,
The maestro no longer could stay.

Because diarrhea with cramping, nausea, and painful straining can strike at the most inopportune time, it takes a comprehensive agent to treat the total diarrheal syndrome and help get the patient back on the job. That's why so many physicians rely on Donnagel, especially during the fall and winter months when "flu" and viral gastroenteritis usually hit their peak.

Donnagel is much more than just a simple kaolin-pectin combination. It also contains the belladonna alkaloids to calm GI hypermotility and help relieve the distressing discomforts which so often accompany diarrhea. Certainly it's less expensive and more convenient than taking two medications. And the dosage is lower too. Available in the handy 4-oz. plastic bottle at pharmacies everywhere on your prescription or recommendation.



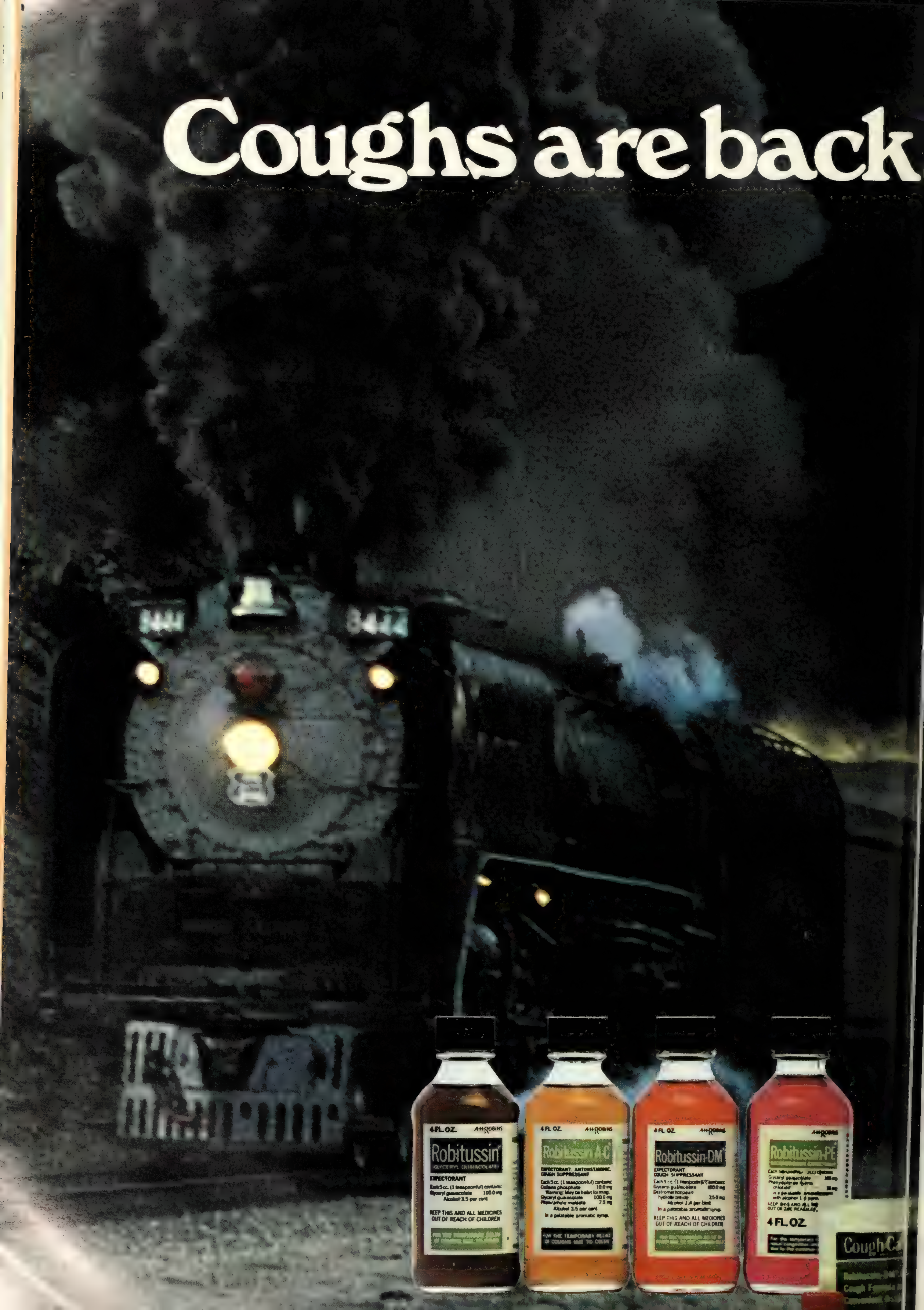
When diarrhea and its discomforts separate a man from his job . . .

Donnagel®

Each fluid ounce contains: Kaolin, 6 g.; Pectin, 142.8 mg.; Hyoscyamine sulfate, 0.1037 mg.; Atropine sulfate, 0.0194 mg.; Hyoscine hydrobromide, 0.0065 mg.; Sodium benzoate (preservative), 60 mg.; Alcohol, 3.8%.

A-H-ROBINS

A. H. Robins Company,
1407 Cummings Drive,
Richmond, Va. 23220


Coughs are back
8444
8444
4 FL. OZ.
A·H·ROBINS
Robitussin
GLYCERYL GUAIACOLATE
EXPECTORANT
Each 5 cc. (1 teaspoonful) contains:
Glyceryl guaiacolate 100.0 mg
Alcohol 3.5 per cent
KEEP THIS AND ALL MEDICINES OUT OF REACH OF CHILDREN
4 FL. OZ.
A·H·ROBINS
Robitussin A-C
EXPECTORANT, ANTIHISTAMINIC, COUGH SUPPRESSANT
Each 5 cc. (1 teaspoonful) contains:
Codeine phosphate 10.0 mg
Warning: May be habit forming.
Glyceryl guaiacolate 100.0 mg
Pheniramine maleate 7.5 mg
Alcohol 3.5 per cent
In a palatable aromatic syrup.
FOR THE TEMPORARY RELIEF OF COUGHS DUE TO COLDS
4 FL. OZ.
A·H·ROBINS
Robitussin-DM
EXPECTORANT
COUGH SUPPRESSANT
Glyceryl guaiacolate
Dextromethorphan hydrobromide 15.0 mg
In a palatable aromatic syrup.
KEEP THIS AND ALL MEDICINES OUT OF REACH OF CHILDREN
A·H·ROBINS
Robitussin-PE
Glyceryl guaiacolate
Phenylephrine hydrochloride
4 FL. OZ.
Cough Ca

clear the tract with the

Robitussin® Line

The coughing season is here again. Time to rely on the four Robitussins and Cough Calmers to help clear the lower respiratory tract. All contain glyceryl guaiacolate, the efficient expectorant that works systemically to help increase the output of lower respiratory tract fluid. The enhanced flow of less viscid secretions soothes the tracheobronchial mucosa, promotes ciliary action, and makes thick, inspissated mucus less viscid and easier to raise. Available on your prescription or recommendation.

For coughs of colds and "flu"

Robitussin®

Each 5 cc. contains:

Glyceryl guaiacolate	100.0 mg.

Alcohol, 3.5%

For unproductive allergic coughs

Robitussin A-C®

Each 5 cc. contains:

Glyceryl guaiacolate	100.0 mg.
Pheniramine maleate	7.5 mg.
Codeine phosphate	10.0 mg.

(warning: may be habit forming)
Alcohol, 3.5%

Non-narcotic for 6-8 hr. cough control

Robitussin-DM®

Each 5 cc. contains:

Glyceryl guaiacolate	100.0 mg.
Dextromethorphan hydrobromide	15.0 mg.

Alcohol, 1.4%

Clears sinuses and nasal stuffiness as it relieves cough

Robitussin-PE®

Each 5 cc. contains:

Glyceryl guaiacolate	100.0 mg.
Phenylephrine hydrochloride	10.0 mg.

Alcohol, 1.4%

Robitussin-DM in solid form for "coughs on the go"

Cough Calmers™

Each Cough Calmer contains:

Glyceryl guaiacolate	50.0 mg.
Dextromethorphan hydrobromide	7.5 mg.

Select the Robitussin® "Clear-Tract" Formulation That Treats
Your Patient's Individual Coughing Needs:

Robitussin® extra benefit chart

All 5 Robitussins have an EXPECTORANT-DEMULCENT action. Keep this handy chart as a guide in selecting the formula that provides the *extra* benefits you want for your patient.

	Cough Suppressant	Antihistamine	Long-Acting (6-8 hours)	Nasal, Sinus Decongestant	Non-Narcotic
ROBITUSSIN®					●
ROBITUSSIN A-C®	●	●			
ROBITUSSIN-DM®	●		●		●
ROBITUSSIN-PE®				●	●
COUGH CALMERS™	AHR		AHR		AHR

A. H. Robins Company, Richmond, Va. 23220 A-H-ROBINS

medical care programs

By Herbert Mehler, Staff Assistant
MSMS Committee on
Governmental-Medical Care Programs

Medicaid in Michigan

Here are the official Medicaid figures from the Michigan Department of Social Services for 1969.

During 1968, physicians' services to 352,920 recipients totaled $25,679,801. Physicians received *14.57%* of total expenditures.

During 1969, physicians' services to 262,040 recipients totaled $20,239,418. This amounted to *11.63%* of the expenditures for this program and is *2.94% LESS* than spent in the previous year.
(See table below)

Comprehensive Health Planning

Resolution 64 of the 1970 MSMS House of Delegates commended the State Comprehensive Health Planning Advisory Council for opposing passage of Senate Bill (Mich) 1756 which would have covered chiropractic services under Blue Shield.

The MSMS Council approved a recommendation from the Committee on Governmental Medical Care Programs concurring in the Comprehensive Health Planning Advisory Council's recommendation to abolish the Comprehensive Health Planning Commission. The Committee believes that this action could improve liaison between State departments, consumers and providers; eliminate a presently unwieldy mechanism and would provide closer contact with the Executive Office for a more effective operation.

Resolution 63 of the MSMS House of Delegates again expressed dissatisfaction that only three (3) practicing physicians presently serve on the State Comprehensive Health Planning Advisory Council. The Resolved stated that "fairness requires that a comparable number of providers, preferably practicing physicians, be added to the State Advisory Council for each additional consumer representative" that the Advisory Council is proposing.

The Wayne County Medical Society has officially withdrawn from participating in comprehensive health planning for the following reasons:

1. Lack of appropriate representation in CHPC and its predecessor, AHOC, particularly in regard to nominations.
2. Lack of due process in the Constitution.
3. Lack of due process in the election.
4. Violation of the Guidelines.

It was suggested that the seven-county (Wayne-Oakland-Macomb-Washtenaw-Monroe-St. Clair-Livingston) southeast Michigan area develop a Health Providers Council for continuity and information. This proposed Council could serve as an advisory group on health planning and possibly develop a positive alternative program.

MEDICAL ASSISTANCE: Recipients and Expenditures by Type of Case and Type of Service January-December 1969[1]

Classification	Recipients[2]	Expenditures	Average per recipient
TOTAL	365,080	$174,022,156	$ 476.67
Type of Case:			
Age 65 and over	82,320	85,079,139	1,033.52
Blind	1,720	1,128,296	655.99
Disabled	38,120	38,689,139	1,014.93
Families with children	223,240	44,254,187	198.24
Other children under age 21	19,680	4,871,395	247.53
Type of Service:			
Inpatient hospital care	78,880	53,875,404	683.00
Outpatient hospital care	116,920	3,612,517	30.90
Nursing home care	33,980	80,903,086	2,380.90
Physicians' services	262,040	20,239,418	77.24
Other practitioners	5,320	360,706	67.80
Home health services	2,100	344,069	163.84
Laboratory and radiology	110,740	2,906,527	26.25
Prescribed drugs	224,520	11,142,045	49.63
Prothesis	720	5,319	7.39
Ambulance	12,080	355,573	29.43
Other	27,860	277,492	9.96

---

1. Data are based on 5 percent sample.
2. The sum of recipients by type of service add to more than the total because more than one type of service was provided to many recipients.

ESSENTIALS OF
OPHTHALMOLOGY

ROLAND I. PRITIKIN

MOORE PUBLISHING COMPANY

P. O. BOX 3143, WEST DURHAM STATION
DURHAM, NORTH CAROLINA, U.S.A. 27705

EDITOR'S NOTE

The purpose of this printing is to make available a book that serves a worthwhile purpose. Part of that purpose is to point up the changes that have occurred during the past two decades, allowing comparison with the old.

It is fitting that such a book should be authored by Roland I. Pritikin, M.D. A member of more societies than we could list on this page, this man has helped in staffing missionary hospitals and teaching students of ophthalmic surgery around the world. Yet the most significant achievements were those of everyday practice in which he has spent these last two decades, sharing in and contributing to the changes that have made a great specialty much greater.

Dr. Pritikin has honored me by asking for my editorial comments.

Eugene V. Grace, M. D.

PRICE $10.00 - 561 PAGES - ILLUS.

Established 1924

MERCYWOOD HOSPITAL

4038 Jackson Road **Conducted by Sisters of Mercy** **Ann Arbor, Michigan**

Telephone — 313 663-8571

Mercywood Hospital is a private neuropsychiatric hospital licensed by the Michigan Department of Mental Health. Mercywood specializes in intensive, multi-disciplinary treatment for emotional and mental disorders.

Accredited by the Joint Commission on Accreditation of Hospitals and the National League of Nursing. A full Blue Cross participating hospital.

Certified for: Medicare and M.A.A. programs

PSYCHIATRIC STAFF

Lyle M. Allis, M.D.
Robert J. Bahra, M.D.
Dean P. Carron, M.D.
Francis M. Daignault, M.D.
Gordon C. Dieterich, M.D.
James R. Driver, M.D.
Robert L. Fransway, M.D.
Stuart M. Gould, Jr., M.D.
Leonard E. Himler, M.D.*
Sydney Joseph, M.D.
Hubert Miller, M.D.
Jacob J. Miller, M.D.
Rudolf Nobel, M.D.
Gerard M. Schmit, M.D.
Richard D. Watkins, M.D.

*1904-1967

Michigan Mediscene

Nov. 29-Dec. 2—Many Michigan physicians will participate in the annual AMA Clinical Convention in Boston

Dec. 2-3—18th Annual Trauma Day, Wayne County Medical Society Headquarters, Detroit

Dec. 9—MSMS Council, MSMS Headquarters, 9:30 a.m., East Lansing

Dec. 9—10th Annual Wayne State University Thyroid Workshop, Wayne County Medical Society Auditorium, Detroit

Jan. 26—Board Meeting, Woman's Auxiliary to MSMS, MSMS Headquarters, East Lansing

Jan. 27—MSMS Council, MSMS Headquarters, East Lansing

Jan. 30-31—Annual Winter Educational Seminar, Michigan State Medical Assistants Society, The Ramada Inn, Saginaw

Jan. 31—Michigan Association of General Practice, all-day meeting on drug abuse, Kellogg Center, East Lansing

Feb. 5-7—Michigan Physical Therapists' report on research, Kellogg Center, East Lansing

March 10—MSMS Council, MSMS Headquarters, East Lansing

April 7-8—10th Annual MSMS Conference on Maternal and Perinatal Welfare, Kellogg Center, East Lansing

April 21—MSMS Council, MSMS Headquarters, East Lansing

April 22—Sixth Annual MSMS Conference on Medical Aspects of High School Sports, Kellogg Center, MSU, East Lansing

April 27-28—Spring Mental Health Meeting, sponsored by Michigan Society for Mental Health, and MSU College of Human Medicine, Department of Psychiatry and Continuing Education Service

April 29-May 1—Annual Scientific Sessions and Heart Days, Michigan Heart Association, Cobo Hall and the Pontchartrain Hotel, Detroit

April 30-May 2—Annual Meeting, Michigan State Medical Assistants Society, Weber's Motor Inn, Ann Arbor

May 21-23—Michigan Kidney Foundation annual and educational meeting, Kellogg Center, East Lansing

May 22-23—Michigan Society of Medical Technologists, annual and educational meeting, Kellogg Center, East Lansing

May 26—MSMS Council, MSMS Headquarters, East Lansing

June 16—MSMS Council, MSMS Headquarters, East Lansing

June 20-24—AMA Annual Convention, Atlantic City

July 22-24—Annual Midsummer Meeting of The MSMS Council, place to be selected

Aug. 25—Optional meeting of The MSMS Council, place to be selected

Oct. 3 and 6—The Council, Pantlind Hotel, Grand Rapids

27th ANNUAL
MIDWEST CLINICAL CONFERENCE

Wednesday, March 3 through Saturday, March 6, 1971

in Chicago's All New
McCORMICK PLACE

- General Clinical Sessions
- Clinical Motion Pictures
- Trauma Program
- Specialty Society Workshops
- Socio-Economic Topics
- Technical and Scientific Exhibits

Continuing Education for All Physicians in Every Specialty

For Preliminary Program Write:

CHICAGO MEDICAL SOCIETY
310 South Michigan Avenue
Chicago, Illinois 60604

GP
ExECG
ICU

You'll find this electro-cardiograph in many places

Burdick's EK 4 — Here's the cardiograph you'll find just about anywhere — in private practice offices, in clinics and group practices, in hospital ICU's, operating, recovery and emergency rooms, military installations, medical schools, stress/exercise procedures, ECG phone transmissions, phonocardiograms — you name it and the Burdick EK 4 is there doing the job!

The EK 4 is a many-dimensioned diagnostic facility in the physician-patient relationship. It's portable, versatile, adaptable, and simple to operate — with special emphasis on patient safety, dependability and diagnostic accuracy. Serviced through your dealer who knows the equipment and understands the needs of the doctor.

The EK 4's performance is its best testimonial.

Your Burdick dealer will be glad to arrange a demonstration at your convenience — or write **The Burdick Corporation, Milton, Wisconsin 53563.**

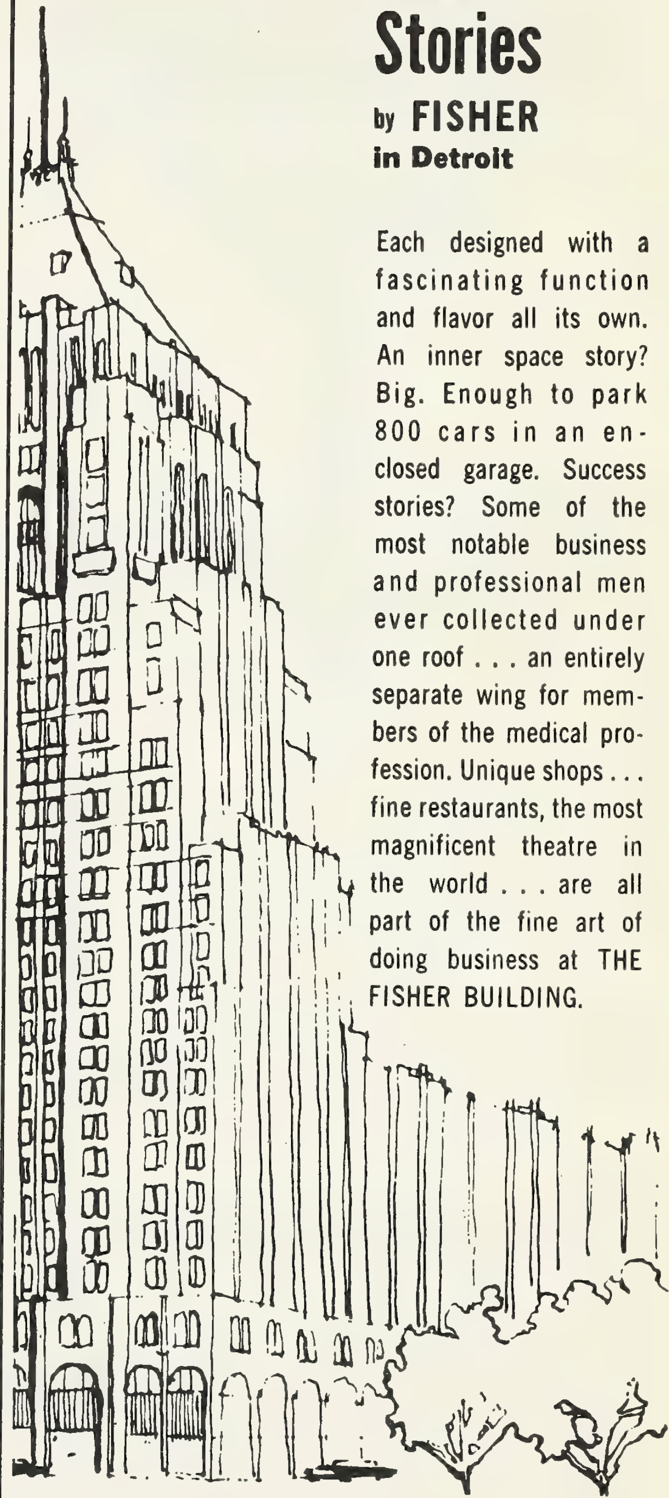
BURDICK

THE G. A. INGRAM COMPANY
4444 Woodward Avenue, Detroit, Michigan 48201
Telephone: TEmple 2-4444

28 Tall Stories

by FISHER
in Detroit

Each designed with a fascinating function and flavor all its own. An inner space story? Big. Enough to park 800 cars in an enclosed garage. Success stories? Some of the most notable business and professional men ever collected under one roof . . . an entirely separate wing for members of the medical profession. Unique shops . . . fine restaurants, the most magnificent theatre in the world . . . are all part of the fine art of doing business at THE FISHER BUILDING.



Call or write the Rental Office

THE FISHER BUILDING

Across from the General Motors Bldg.
Detroit, Mich. 48202 (313)874-4444

CONSTIPATION
EVACUATE GENTLY

With EVAC-U-GEN — your patients with functional constipation can evacuate gently. Because EVAC-U-GEN has a mild laxative action and tends to cause the stool to be soft — it is highly desirable for those sensitive to harsh laxatives — particularly children, pregnant women, and geriatric patients. Recommend EVAC-U-GEN for the management of functional constipation. It is highly effective. Non-griping. Chewable. Very palatable. Economical.

EVAC-U-GEN®

A highly-flavored and palatable tablet of yellow phenolphthalein, bismuth subcarbonate, bismuth subgallate in special base. Chewable. Bottles of 35 and 100. Adult Dose: Chew 1 or 2 tablets night or morning. Children (up to age 10): 1/2 tablet. A citrus drink taken with tablet will stimulate action.
PRECAUTION: Do not use when symptoms of appendicitis are present and discontinue use if skin rash appears. Dependence on laxatives can result from continued use.

W-C PRECISION PHARMACEUTICALS

SEND FOR SAMPLES.
WALKER, CORP & CO., INC.
Syracuse, New York 13201

about doctors

Harold F. Falls, M.D., Ann Arbor, represented MSMS at the AMA's Council on Health Manpower Oct. 22-24 at the Palmer House in Chicago. Doctor Falls is a past member of The MSMS Council and belongs to the MSMS Committees on Planning and Priorities and Finance. He was accompanied at the meeting by John A. Doherty, director of the Michigan Health Council.

Winthrop N. Davey, M.D., Ann Arbor, has been appointed to the National Heart and Lung Advisory Council of the National Heart and Lung Institute. He is professor of medicine at the U-M.

C. Mark Vasu, M.D., Grand Rapids, has received a commendation signed by President Richard M. Nixon "in recognition of exceptional service to others, in the finest American tradition." The citation commends the work Doctor Vasu and other Grand Rapids physicians have done to improve care of accident victims in Kent County.

Donald H. Lakin, M.D., Grosse Pointe Woods, and Harold F. Falls, Ann Arbor have been nominated for the Humanitarian Award for Eye Care, of the National Eye Research Foundation. The award will be presented during the 16th national congress of the foundation in November, 1971.

John M. Weller, M.D., Ann Arbor, is new chairman of the Scientific Advisory Board of the Kidney Foundation of Michigan. He is professor of internal medicine at the University of Michigan Medical School.

Matthew R. Kinde, M.D., Battle Creek, retired Oct. 3 as director of the W. K. Kellogg Foundation's division of medicine and public health. Doctor Kinde has been a leader in medical developments from the time of the first county health departments.

Harold C. Mack, M.D., Detroit, chairman of the WSU Department of Obstetrics and Gynecology since 1962, has been named professor emeritus. He retired from the university on Sept. 1.

Michigan Physicians May Face 1971 Draft

By Judith Marr
Managing Editor

Indications are that young Michigan physicians may face a 1971 draft.

If the armed forces are reduced fast enough and an all-volunteer army established, the draft of state physicians may not be necessary, according to a Michigan selective service official.

But presently, according to Maj. Max Strothers, Michigan Selective Service operational staff officer in charge of health specialist procurement, a 1971 draft is possible.

An article in the Sept. 28 issue of *Medical World News* definitely states that young U.S. physicians will be drafted in 1971.

According to that article, the major reasons are a 40% drop in basic Berry Plan applications and a six-fold increase in applicants indicating they will leave the Berry Plan program if not allowed a "full delay" in order to complete residency in the specialty of their choice.

Maj. Strothers points out that there has been no call for Michigan physicians since the last one processed in June, 1969, and carried out in July, August and September of 1969.

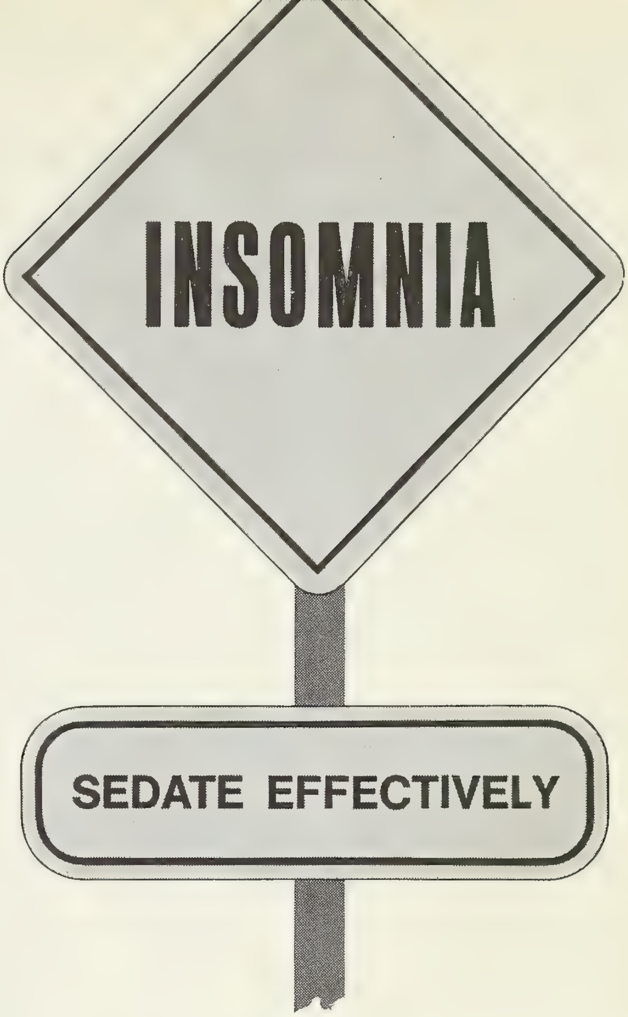
"And if history repeats itself the volunteering will fall to a dangerous level and the armed forces' manpower procurement will have to be augmented," says Maj. Strothers.

The Defense Department is now urging medical school graduates to reconsider their decision to withdraw from the Berry Plan in order to avoid serving.

Medical World News reports that those who do not accept earlier active duty under the Berry Plan will join other recent MDs in the most draft-vulnerable sector of a medical manpower pool destined to be tapped for military service beginning sometime in the summer of 1971.

According to *Medical World News,* Defense Department requisitions will be forwarded to Selective Service early this winter, a randomized selection will be made, and the first special draft calls will be issued shortly after the first of the year.

Comparisons of past years made by the magazine indicate that between 1,000 and 2,000 young physicians will receive draft notices.



With QUĪ-A-ZONE – you can sedate effectively. A balanced combination of short, intermediate, and long-acting barbiturates (totaling 100 mg.) in a rapidly disintegrating tablet – sedation is provided within a few minutes . . . followed by sound restful sleep . . . usually without morning hangover. The four barbiturates in QUĪ-A-ZONE have dual channels of elimination (renal and hepatic) to lessen metabolic burden, decrease barbiturate retention, and minimize depression.

QUĪ-A-ZONE™

Each rapidly-disintegrating tablet contains 25 mg. secobarbital, 25 mg. pentobarbital, 25 mg. butabarbital, and 25 mg. phenobarbital. Bottles of 100.
Usual Adult Dose: 1 to 2 tablets before retiring.
PRECAUTION: Should not be administered to patients sensitive to barbiturates, or in cases of known previous addiction. Warning: May be habit forming.

W-C PRECISION PHARMACEUTICALS

SEND FOR SAMPLES.

WALKER, CORP & CO., INC.
Syracuse, New York 13201

Gone with the wind

The gas/acid group of disorders

The two most common complaints referable to the upper gastrointestinal tract for which patients seek medical relief are hyperacidity and 'gas.' The two often occur together."*

Frees captured gas...neutralizes free acid

SILAIN-GEL Tablets and Liquid are separate formulas designed to provide equivalent dual-action symptomatic relief. Both dosage forms contain simethicone which effectively frees trapped gas, enabling the patient to eliminate it. Magnesium hydroxide in both assures a rapid rise in pH for prompt relief of hyperacidity. The special co-dried aluminum hydroxide/magnesium carbonate gel in the tablets assures the same rapid and uniform reaction rate as the liquid. Thus, both medications achieve prompt and prolonged neutralization of free acid *plus* prompt relief from the pain and pressure of trapped gas.

Always in good taste

The pleasant, distinctive flavor of SILAIN-GEL, as well as its non-constipating feature, make it a therapy your patients can live with—in comfort and without complaint.

Select the form of SILAIN-GEL you want to provide symptomatic relief in:
gastric ulcer • duodenal ulcer • heartburn • gastric hyperacidity •
gastritis • dyspepsia

when the patient prefers the convenience of a tablet, select

Silain-Gel® Tablets:

when the patient prefers a liquid, select

Silain-Gel® Liquid

Also available for the patient who needs an antifrothicant/antiflatulent agent only: **Silain®** (simethicone) Tablets

*Slanger, A.: Med. Times 94:150 (Feb.) 1966.

Announcing the "Antgasid"

Silain-Gel®

Tablets: simethicone plus aluminum hydroxide/magnesium carbonate co-dried gel and magnesium hydroxide

Liquid: simethicone plus aluminum hydroxide and magnesium hydroxide

One dose does both: frees captured gas...neutralizes free acid

A·H·ROBINS A.H. Robins Company, Richmond, Virginia 23220

The Doctor

One of the doctor's most important roles is in education.

For his patients, the physician provides the facts, supplies the rationale, triggers the action for life-saving health practices. To his students, he passes on his knowledge and the benefits of his clinical experience. With his colleagues, he shares new information and concepts.

Assisting the doctor in his teaching role is a major function of our professional education program. Through medical conferences, films, exhibits, pamphlets, monographs and other publications, we provide him with the most important and current information on cancer.

If, as Henry Brooks Adams speculated, "A teacher affects eternity; he can never tell where his influence stops", the outlook is optimistic.

doc'tor (dok'ter), *n.* (ME. *doctour,* fr. OF. *doctour.* fr.L. *doctor* teacher, fr. *docere* to teach.) 1. A teacher; one skilled in a profession, or branch of knowledge; a learned man.

American Cancer Society

Pat Hudson has angina.
But he hardly ever thinks about it.

New STEPS™ PENTAERYTHRITOL TETRANITRATE

Timed Disintegration Capsules

Give him prophylaxis against angina pectoris
Convenience of twice-a-day dosage
Greater peace of mind

Each capsule is designed to provide vasodilating effect for up to 12 hours. Conventional dosage forms of pentaerythritol tetranitrate (PETN), which must be taken every 3 to 4 hours, keep some patients reminded of their disability throughout the day. And some, taking short-acting dosage forms, become quite apprehensive about being without medication while asleep.

Dosage range that now lets you control nitrite therapy.

STEPS pentaerythritol tetranitrate timed disintegration capsules not only give the patient more convenience and peace of mind, they let you prescribe the dose an individual patient needs.

STEPS comes in 3 potencies—30 mg. 50 mg. and 80 mg.—to help you determine the optimal level of effectiveness in providing relief from the frequency and intensity of anginal attacks.

The wide potency range of STEPS allows you to adjust the dosage to meet the patient's needs. Moreover, if therapy must be altered or discontinued due to nitrite tolerance, the flexible dosage of STEPS permits resumption of therapy at the smallest effective dose.

(See next page for complete dosage recommendations and precautions.)

New

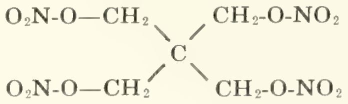
STEPS™ PENTAERYTHRITOL TETRANITRATE

Timed Disintegration Capsules

Available in three potencies for greater dosage flexibility and better control of therapy.

CAUTION: Federal law prohibits dispensing without prescription.

DESCRIPTION: Pentaerythritol Tetranitrate Structural Formula:



Empirical Formula: $C_5H_8N_4O_{12}$ Molecular Weight: 316.15. The pentaerythritol tetranitrate is in a special timed disintegration base providing for prolonged therapeutic effect.

MODE OF ACTION: The mechanism of action in the relief of angina pectoris is unknown at this time, although the basic pharmacologic action is to relax smooth muscle.

INDICATIONS: For the relief of angina pectoris (pain of coronary artery disease). It is not intended to abort the acute anginal episode, but is widely regarded as useful in the prophylactic treatment of angina pectoris.

CONTRAINDICATIONS: Idiosyncrasy to this drug.

WARNINGS: Data supporting the use of nitrites during the early days of the acute phase of myocardial infarction (the period during which clinical and laboratory findings are unstable) are insufficient to establish safety. Keep out of reach of children.

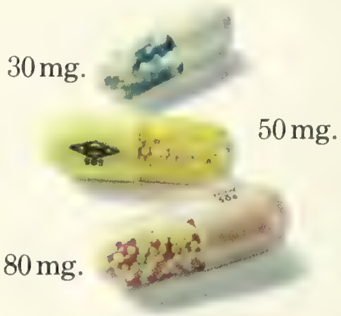
PRECAUTIONS: Intraocular pressure is increased; therefore, caution is required in administering to patients with glaucoma. Tolerance to this drug, and cross-tolerance to other nitrites and nitrates may occur.

ADVERSE REACTIONS: Cutaneous vasodilation with flushing. Headache is common and may be severe and persistent. Transient episodes of dizziness and weakness, as well as other signs of cerebral ischemia associated with postural hypotension, may occasionally develop. This drug can act as a physiological antagonist to norepinephrine, acetylcholine, histamine, and many other agents. An occasional individual exhibits marked sensitivity to the hypotensive effects of nitrite and severe responses (nausea, vomiting, weakness, restlessness, pallor, perspiration and collapse) can occur, even with the usual therapeutic dose. Alcohol may enhance this effect. Drug rash and or exfoliative dermatitis may occasionally occur.

DOSAGE AND ADMINISTRATION: One capsule every 12 hours on an empty stomach. (Not recommended for sublingual use.)

HOW SUPPLIED: STEPS pentaerythritol tetranitrate timed disintegration capsules are available in 30 mg. (NDC 183-504-2), 50 mg. (NDC 183-505-2), and 80 mg. (NDC 183-506-2) sizes. Each capsule size is packaged in bottles of 100.

STORAGE: Capsules should be stored in a cool, dry place in a light-resistant container out of the reach of children.



THE DOW CHEMICAL COMPANY
Rx Pharmaceuticals, Indianapolis

in memoriam

Don H. Bellinger, D.D.S.
Saginaw

Don H. Bellinger, D.D.S., Saginaw oral surgeon and member of the Saginaw County Medical Society, died Oct. 2 at the age of 74. Doctor Bellinger was also a member of MSMS.

E. Leo Bennish, M.D.
Southfield

E. Leo Bennish, M.D., Southfield physician and member of the faculty of the Wayne State University School of Medicine, died Oct. 17 at the age of 47.

Doctor Bennish was on the staffs of the Sinai, Providence and North Detroit General Hospitals and was also a diplomate of the American Board of Orthopedic Surgeons and a member of the American College of Surgeons.

Fritz W. Bramigk, M.D.
Detroit

Fritz Wilhelm Bramigk, M.D., Ph.D., Detroit physician for 46 years, died Oct. 7 at the age of 83.

Born and educated in Germany, Doctor Bramigk came to the United States shortly after receiving his medical degree in 1923. He specialized in internal medicine.

He was a member of the Trudeau Society, American Geriatric Society, American Academy of Nutrition, New York Academy of Sciences, and the Michigan Tuberculosis Association.

Doctor Bramigk served on the staffs of Herman Kiefer Hospital and Maybury Sanatorium in Detroit.

Margery J. Gilfillan, M.D.
St. Petersburg

Margery Jane Gilfillan, M.D., a former Battle Creek Sanitarium neurologist for 30 years, died Oct. 12 at the age of 94. She was residing in St. Petersburg, Fla.

Doctor Gilfillan was a graduate of Rush Medical College and practiced in Canton, Ohio and Hastings, Neb. She also practiced on the staff of the state hospital in Kalamazoo and in Oconomowoc, Wis., and Stamford, Conn. She was a member of the American Psychiatric Association.

J. Paul McConkie, M.D.
Detroit

J. Paul McConkie, M.D., of Detroit, who had a general practice in Birmingham for 40 years, died Sept. 29 at the age of 70.

Doctor McConkie was an honorary staff member of St. Joseph's Mercy Hospital, Pontiac, and was a graduate of the University of Iowa Medical School.

Elisha Sevensma, M.D.
Grand Rapids

Elisha Sevensma, M.D., Grand Rapids general practitioner for over 60 years, died Oct. 15 at the age of 91.

Doctor Sevensma held life memberships in the Kent County and Michigan State Medical Societies and was associated with Butterworth Hospital in Grand Rapids from the day in 1910 when he graduated from Detroit College of Medicine.

Doctor Sevensma was a former St. Clair High School principal, Calvin College faculty member and member of the Grand Rapids Board of Education.

Bert Van Ark, M.D.
Eaton Rapids

Bert Van Ark, M.D., long time Eaton Rapids physician, died Oct. 13 at the age of 73.

Doctor Van Ark was a general practictioner and was affiliated with Eaton Rapids Community Hospital. He was past president of the Eaton County Medical Society and served on the MSMS Diabetes and Medical Legal Committees.

Duane R. Worgess, M.D.
Battle Creek

Duane R. Worgess, M.D., Battle Creek general practitioner, died Oct. 15 at the age of 49. He had been ill a long time.

Doctor Worgess was a graduate of Northwestern University School of Medicine and was affiliated with Community Hospital and Leila Y. Post Montgomery Hospitals and the Battle Creek Health Center.

PUBLISHED TO REPLACE A PREVIOUS ADVERTISEMENT WHICH THE FOOD AND DRUG ADMINISTRATION CONSIDERED MISLEADING

The Food and Drug Administration has requested that we bring to your attention a recent promotional campaign for Garamycin Injectable (gentamicin sulfate) which featured a nationwide *in-vitro* hospital survey involving a comparison of sensitivity patterns of Garamycin Injectable and seven other antibiotics.

The FDA considers the advertising misleading in several respects such as:

The *in-vitro* chart contained in the ads, which compared Garamycin Injectable with seven other antibiotics, implied that Garamycin Injectable is clinically more effective than the seven other compared antibiotics. THE FACTS ARE (1) THAT DIRECT EXTRAPOLATION OF NONCLINICAL FINDINGS TO CLINICAL EFFECTIVENESS IS UNWARRANTED, AND (2) THAT THE ADVERTISED *IN-VITRO* COMPARISONS DO NOT CONSTITUTE A VALID BASIS FOR SUGGESTING THAT GARAMYCIN INJECTABLE HAS GREATER CLINICAL EFFECTIVENESS THAN THE COMPARED ANTIBIOTICS.

The *in-vitro* chart and information contained under the ad heading, "Indications" presented *in-vitro* data results in such a way as to imply that the drug is indicated for Gram-positive bacteria, such as *Staphylococcus aureus.* GARAMYCIN INJECTABLE IS NOT APPROVED FOR INFECTIONS DUE TO ANY GRAM-POSITIVE ORGANISMS.

We emphasize that Garamycin Injectable is approved for use only in infections due to susceptible strains of gram-negative bacteria, including Pseudomonas aeruginosa, and species of indole-positive and indole- negative Proteus, Escherichia coli, and Klebsiella-Aerobacter.

Schering

Injectable Garamycin®

brand of

gentamicin sulfate injection

Each cc. contains gentamicin sulfate equivalent to 40 mg. gentamicin

BRIEF SUMMARY

INDICATIONS GARAMYCIN Injectable is clinically effective in infections due to susceptible strains of gram-negative bacteria, including Pseudomonas aeruginosa, and species of indole-positive and indole-negative Proteus, Escherichia coli, and Klebsiella-Aerobacter. Bacteriologic studies should be conducted to identify the causative organism and to determine its sensitivity to gentamicin sulfate. Sensitivity discs of the drug are available for this purpose. If the susceptibility tests indicate that the causative organism is resistant to gentamicin sulfate, other appropriate antibiotic therapy should be instituted.

This drug should be limited to the treatment of serious infections caused by gram-negative bacteria, particularly Pseudomonas aeruginosa, Proteus and other susceptible organisms, with due regard for relative antibiotic toxicity. Therefore, the drug should be considered for use against gram-negative: 1. Bacteremia; 2. Infected surgical wounds; 3. Severe soft tissue infections, including burns complicated by sepsis; 4. Respiratory tract infections; and 5. Selected cases of urinary tract infection.

CONTRAINDICATIONS GARAMYCIN Injectable is contraindicated in individuals with a history of hypersensitivity or toxic reactions to gentamicin.

WARNINGS Patients receiving treatment with GARAMYCIN should be under close clinical observation because of the toxicity associated with the use of this drug. Ototoxicity, vestibular and auditory, can occur in patients, primarily those with pre-existing renal damage, treated with GARAMYCIN Injectable, usually for longer periods or with higher doses than recommended.

GARAMYCIN Injectable is potentially nephrotoxic, and this should be kept in mind when it is used in patients with pre-existing renal impairment. Kidney function diminished by infection of the upper urinary tract may, however, improve during effective treatment with GARAMYCIN Injectable.

Concurrent administration of potentially ototoxic drugs such as streptomycin and kanamycin or of potentially nephrotoxic drugs such as polymyxin, colistin, and kanamycin with gentamicin sulfate has not been shown to afford any clinical advantages and, moreover may result in additive toxicity. Monitoring of vestibular, cochlear, and renal function will provide guidance for therapy in such cases.

PRECAUTIONS In patients with impaired renal function in whom serious infection develops, serum concentrations of the drug may rise, with consequently increased risk of ototoxicity. In these patients or in those in whom recommended dosage or duration of therapy must be exceeded as a life-saving measure, routine studies of kidney function should be performed when possible. These may be supplemented by evaluation of the vestibular and auditory function and measurement of serum concentration of the drug when feasible. Serum concentration of gentamicin should be maintained below the range of 10-12 mcg./ml. to reduce risk of ototoxicity.

Ordinarily, treatment should not be given for more than 7 to 10 days or be repeated unless required for serious infection not responsive to other agents.

As with other antibiotics, treatment with GARAMYCIN Injectable may occasionally result in overgrowth of nonsensitive organisms. If superinfection occurs, appropriate therapy is indicated.

Safety for use in pregnancy or the potential for fetal ototoxicity or nephrotoxicity have not been established. Studies in pregnant animals have not revealed teratogenic or ototoxic effects in the fetus. GARAMYCIN Injectable should not be used in pregnant patients or in women of childbearing age unless its use is deemed advisable by the physician.

ADVERSE REACTIONS The overall incidence of ototoxicity considered related to treatment with GARAMYCIN Injectable was 2.8 per cent (16 of 565 patients). Contributory factors (two or more factors were relevant to most patients) were as follows: 10 had azotemia, 10 received a total of 1 gram or more of the drug, 7 had recently received other potentially ototoxic antibiotics (streptomycin or kanamycin), and 5 were over 60 years of age. Six also had decreased high-tone hearing acuity, which returned to or toward normal in the 4 patients retested.

Analysis of BUN data indicated that 4 (2%) of 172 patients showed increases in BUN that were probably related to treatment with GARAMYCIN Injectable. Of 20 increases probably or possibly related to treatment, 7 were reversible, 9 occurred in terminal patients, and 4 had no follow-up.

Other adverse reactions associated with treatment were one instance each of urticaria, decreased hematocrit, and reversible depression of granulocytes with normal bone marrow. Other rarely reported and possibly treatment-related adverse reactions were anemia, increased reticulocyte count, rash, purpura, drug fever, hypotension, convulsions, twitching, salivation, nausea, vomiting, increased transaminase activity (SGOT or SGPT), increased serum bilirubin, decreased serum calcium, and joint pain.

PACKAGING GARAMYCIN Injectable, 40 mg./cc., 2-cc. multiple-dose vials, for intramuscular administration.

SCHERING CORPORATION, UNION, NEW JERSEY 07083

SCH-2620

Specialized Service

IN

PROFESSIONAL LIABILITY INSURANCE

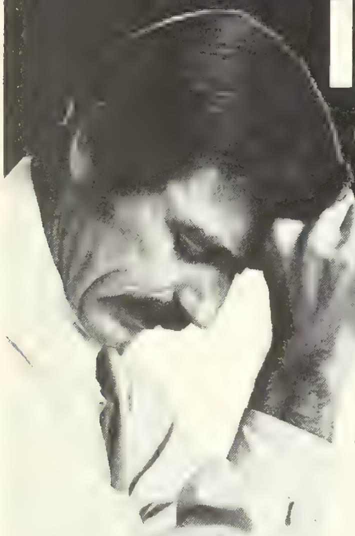
is a high mark of distinction

THE
MEDICAL PROTECTIVE COMPANY
FORT WAYNE, INDIANA

Professional Protection Exclusively since 1899

DETROIT OFFICE: R. K. Wind and J. K. Galloway, Representatives
27200 Lahser Road, Southfield 48075, Telephone: (Area Code 313) ELgin 3-4848 or 444-1439

GRAND RAPIDS OFFICE: G. J. Haworth, Representative
422 Federal Square Building, Grand Rapids 49502 Telephone: 616-454-4477



The treatment of

impotence

due to androgenic deficiency in the American male. The concept of chemotherapy plus the physician's psychological support is confirmed as effective therapy.

NEW CLINICAL STUDY

The Treatment of Impotence
with Methyltestosterone Thyroid
(100 patients—Double Blind Study)
T. Jakobovits
Fertility and Sterility, January 1970
Official Journal of the
American Fertility Society

Android®
(thyroid-androgen) tablets

Double-Blind Study and Type of Patient: 100 patients suffering from impotence. Of the patients receiving the active medication (Android) a favourable response was seen in 78%. This compares with 40% on placebo. Although psychotherapy is indicated in patients suffering from functional impotence the concomitant role of chemotherapy (Android) cannot be disputed.

Choice of 4 strengths:

Android	**Android-HP**	**Android-X**	**Android-Plus**
	HIGH POTENCY	EXTRA HIGH POTENCY	WITH HIGH POTENCY B-COMPLEX AND VITAMIN C
Each yellow tablet contains:	*Each red tablet contains:*	*Each orange tablet contains:*	*Each white tablet contains:*
Methyl Testosterone ..2.5 mg.	Methyl Testosterone ..5.0 mg.	Methyl Testosterone .12.5 mg.	Methyl Testosterone ..2.5 mg.
Thyroid Ext. (1/6 gr.) ..10 mg.	Thyroid Ext. (½ gr.) ...30 mg.	Thyroid Ext. (1 gr.) ....64 mg.	Thyroid Ext. (¼ gr.) ...15 mg.
Glutamic Acid ....50 mg.	Glutamic Acid ....50 mg.	Glutamic Acid ....50 mg	Ascorbic Acid (Vit. C) .250 mg.
Thiamine HCL ....10 mg.	Thiamine HCL ....10 mg.	Thiamine HCL ....10 mg.	Thiamine HCL ....25 mg.
Dose: 1 tablet 3 times daily.	*Dose:* 1 tablet 3 times daily.	*Dose:* 1 or 2 tablets daily.	Glutamic Acid ....100 mg.
Available:	*Available.*	*Available:*	Pyridoxine HCL ....5 mg.
Bottles of 100, 500, 1000.	Bottles of 100, 500, 1000.	Bottles of 60, 500.	Niacinamide ....75 mg.
REFER TO PDR			Calcium Pantothenate .10 mg.
			Vitamin B-12 ....2.5 mcg.
			Riboflavin ....5 mg.
			Dose: 2 tablets daily.
			Available: Bottles of 60, 500.

Contraindications: Android is contraindicated in patients with prostatic carcinoma, severe cardiorenal disease and severe persistent hypercalcemia, coronary heart disease and hyperthyroidism. Occasional cases of jaundice with plugging biliary canaliculi have occurred with average doses of Methyl Testosterone. Thyroid is not to be used in heart disease and hypertension

Warnings: Large dosages may cause anorexia, nausea, vomiting abdominal pain, diarrhea, headache, dizziness, lethargy, paresthesia, skin eruptions, loss of libido in males, dysuria, edema, congestive heart failure and mammary carcinoma in males

Precautions: If hypothyroidism is accompanied by adrenal insufficiency the latter must be corrected prior to and during thyroid administration

Adverse Reactions: Since Androgens, in general, tend to promote retention of sodium and water, patients receiving Methyl Testosterone, in particular elderly patients, should be observed for edema.

Hypercalcemia may occur, particularly in immobilized patients: use of Testosterone should be discontinued as soon as hypercalcemia is detected

References: 1. **Montesano, P., and Evangelista, I.** Methyltestosterone-thyroid treatment of sexu impotence. Clin Med 12:69, 1966. 2. **Dublin, M. F.** Treatment of impotence with methyltestosteron thyroid compound West Med 5:67, 1964 3. **Titeff, A. S.** Methyltestosterone-thyroid in treating impotenc Gen Prac 25:6, 1962 4. **Hellman, L., Bradlow, H. L., Zumoff, B., Fukushima, D. K., and Gallagher, T.** Thyroid-androgen interrelations and the hypocholesteremic effect of androsterone. J Clin Endocr 19:93 1959. 5. **Farris, E. J., and Colton, S. W.** Effects of L-thyroxine and liothyronine on spermatogenesi J Urol 79:863, 1958. 6. **Osol, A., and Farrar, G. E.** United States Dispensatory (ed. 25). Lippincott, Phil delphia, 1955, p. 1432. 7. **Wershub, L. P.** Sexual Impotence in the Male. Thomas, Springfield, Ill., 1959, pp. 79-99.

Write for literature and samples: BROWN **THE BROWN PHARMACEUTICAL CO., INC.** 2500 West 6th Street, Los Angeles, California 9005

Someone acutely ill needs this bed.

t's available because of Medicenter.

ecause of Medicenter, this hospital bed can be used someone who needs it. That's what Medicenter is about. A recuperative care facility specializing in the ds of patients who no longer require the intensive care a general hospital and who are on the road to recovery. ut that's only part of the Medicenter story . . . Beauti- y carpeted and draped patient rooms, tasty foods, rec- ion facilities, physical and inhalation therapy are a few of many luxurious health care features that e recovery in the Medicenter as pleasant and rapid as possible. The Medicenter is within minutes of acute care facilities. A professional medical staff supervises all recuperative care under the direct orders of each patient's personal physician. Room rates are nominal — about one-half the cost of general hospitals. And there's a growing list of insurance companies that already provide coverage for Medicenter recuperation.

The Medicenter is a vital addition to our community's health care system. Get to know the Medicenter soon. Your visit or inquiry is welcome anytime.

MEDiCENTER
OF AMERICA
®

A Nice Place to Get Well

Medicenter of America / Chelsea • Escanaba • Flint, Michigan

Classified Advertising

$5.00 per insertion of 50 words or less, with an additional 10 cents per word in excess of 50.

FAMILY PRACTICE PHYSICIANS – Board of Trustees of St. Mary's Hospital in Marquette invites family practice physicians to practice in Michigan's upper peninsula. This community has two hospitals, excellent schools, churches and year-round sports activities. This hospital is a 126 bed modern, well equipped, JCAH accredited general hospital including psychiatric and rehabilitation units in which to practice professional skills. Interested physicians may contact: Archie S. Narotzky, M.D., Chief of Staff, St. Mary's Hospital, Marquette, Michigan 49855.

ANN ARBOR–YPSILANTI AREA. 3 yr. AMA approved, university affiliated psych. residency at mental health center offering comprehensive services to SE Mich. Teaching faculty & supervisors include U. of M. faculty, private psychiatrists & analysts, as well as hospital staff. Resident's time divided approx. equally between didactic seminars (including supervision) & clinical experience. First year ADM & Intensive Treatment Units; second & third year assigned Community Psych. and/or OPC and/or Children's unit. Additional experience in psychosomatic medicine, Univ. Mental Hygiene Clinic, and neurology. 3-year: $11,358 to $12,924. 5-yr: $12,945 to $23,197. $15,000 NIMH grants & dependency allowance ($500 per) available to eligible physicians in practice 4+ years. Contact: J. Tiziani, M.D., Ypsilanti State Hospital, Ypsilanti, Michigan 48197.

Semi-retire in Florida!! Clean air, fishing and beaches. Emergency room physicians needed full time for expanding Florida Hospital. Must have Florida License and qualify for Active Staff privileges. Fee for service with Guarantee of $300 per 24 hour day. No overhead. Hospital does billing of fees at no expense to you. Write E. Gilbert Slatton, Administrator, Wuesthoff Memorial Hospital, Rockledge, Florida 32955.

WANTED: General practitioner to join active group in large non-OB, non-pediatric practice with large industrial component. Well established. New building. X-Ray–Laboratory facilities–Cincinnati area. Future bonanza for right person willing to work. Reply Box 18, 120 West Saginaw Street, East Lansing, Michigan 48823.

POSITION OPEN NOW: Medical Society seeking full time medical director for urban-rural Lenawee County Health Department. Population 80,000. Salary $25,000. Reply Box 23, 120 West Saginaw Street, East Lansing, Michigan 48823.

Physician for private industrial clinic needed. Work is varied and includes much office surgery. Hours are regular with no night work. $30 to $35,000/annum to start with rapid advancement and in quick order entrance into a profit sharing plan. We also have a pension plan, insurance program, and liberal vacation policy. Please write or call: R. R. Silver, M.D., 24425 Hoover Road, Warren, Michigan 48089 (313) 756-5800.

NEW EXPANDING OPPORTUNITIES for family physicians and physicians specializing in pediatrics, internal medicine, urology, anesthesiology; in medically-awakening community. Contemporary, automated, 105-bed, new hospital to be completed in the fall of 1970. Present hospital to be converted into long-term unit. Patient service area 50,000 people. Medical staff leading and supporting recruitment efforts. Excellent community location, forty miles equidistant to Milwaukee or Madison. Complete educational, cultural and recreational facilities. A new medical – dental building and a 130-bed skilled care nursing home being constructed adjacent to the new hospital ready for occupancy January 1971. Immediate satisfaction in practice, income and family living. Special assistance if needed. Write or call Paul R. Glunz, M.D., Watertown Memorial Hospital, 1301 E. Main Street, Watertown, Wisconsin 53094; Telephone (414) 261-4210 for more information.

VACATION ON FLORIDA'S GOLD COAST: 2 bedroom T-bird villa in Coral Springs. Quiet and private. 18 hole golf course, tennis, swimming pool on premises. Available year-round on monthly or weekly rental basis. Rest and recuperate that weary mind and body. Contact Dr. J. Heidenreich, Marshall, Michigan (616) 781-7997.

GENERAL PRACTITIONER: For pension examinations and Admitting Officer assignment. 233-bed hospital in small Michigan community offering ideal family living, a superior school system, and all seasons sports vacation-land. Full staff of highly qualified physicians; 80% of whom are Board Certified. Licensure any state. U. S. citizenship. Salary based on qualifications. Excellent fringe benefits. Non-discrimination in employment. Contact: Chief of Staff, VA Hospital, Iron Mountain, Michigan 49801.

Internist, OB-GYN, Radiologist, and Urologist needed for additional staff to established 15 man medical group in Detroit. Excellent financial opportunities and fringe benefits. Box 20, 120 West Saginaw Street, East Lansing, Michigan 48823.

BOARD CERTIFIED PSYCHIATRIST. Average daily census–1204; predominately psychiatric VA hospital, located in East Central Indiana. Special programs in psychiatric and geriatric rehabilitation; alcoholic treatment unit. Active medical service. Family rental units at reasonable rates usually available on hospital grounds. 30 days leave annually; retirement; health, life insurance plans without physical examination; and other benefits. Will pay moving expenses. Salary $19,643-$29,752 depending on qualifications. License any state required. Equal opportunity employer. Contact Chief of Staff, VA Hospital, Marion, Indiana 46952 or call Area 317, 674-3321.

GENERAL PRACTICE, well established. Recent death. Modern building with parking. Will sell or lease building and equipment. Payment from income. Central Michigan. Trust Department, Security National Bank, Battle Creek, Michigan.

Washtenaw Society Assisting Pilot Project

A pilot project in family planning is underway in Washtenaw County, with the co-operation of the Washtenaw County Medical Society.

The Executive committee of the WCMS approved the program, established to help those with financial need and otherwise unable to obtain family planning service. Over 20 physicians have agreed to participate.

The program was to get underway early in November, after guidelines were written and distributed for physicians, nurses and others involved.

The program is sponsored by the Washtenaw County Health Department and will use services of private physicians and Planned Parenthood clinics.

"Our participation demonstrates the interest and willingness of the privately practicing physician to provide a badly-needed service," says George Koepke, M.D., president of the Washtenaw County Medical Society. "This shows we really are sincere in trying to help the needy."

INTERNIST-GASTROENTEROLOGIST: Would like to associate or work with another internist or small group, part or full time, in Detroit or preferably its northern suburbs. Reply Box 25, 120 West Saginaw Street, East Lansing, Michigan 48823.

FOR SALE OR RENT: Ophthalmologist's office equipment. Two B & L Deluxe Chairs, Green Refractors/Perimeter. Medico Record Files. Much other equipment. Space could be rented as a going practice. Retiring. Reply Box 24, 120 West Saginaw St., East Lansing, Michigan 48823.

WANTED: Full-time Emergency Room Physicians (s) to join a four man group in a 300 bed hospital. Michigan license required. Remuneration $42,000 including fringe benefits annually; 48 hour week; rotating hours and week-ends. Address inquiries to: G. Petropoulos, M.D., Annapolis Hospital, Wayne, Michigan.

Advertisers in MICHIGAN MEDICINE are friends of the profession. By accepting their advertising we show confidence in them, their services and products. They help make the journal a quality publication. Please familiarize yourself with their services and products and let them know that you see their advertising in MICHIGAN MEDICINE.

Ef-
fic-
iency

Dicarbosil®
ANTACID

Your ulcer patients and others will confirm it. Specify DICARBOSIL 144's—144 tablets in 12 rolls.

ARCH LABORATORIES
319 South Fourth Street, St. Louis, Missouri 63102

Index to Advertisers

American Cancer Society 1096
Arch Laboratories 1107
Brown Pharmaceutical Co. 1104
Campbell Soup Co. 1079
Chicago Medical Society 1090
Classified Advertising 1106, 1107
Dow Chemical Co. 1097, 1098, 1099, 1100
Fisher Bldg., The 1091
Hynson, Westcott and Dunning 1055
Ingram, G. A. Co. 1091
Lederle Laboratories 1056
Lilly, Eli and Co. 1062
Loma Linda Foods . . . . . Cover III
Medical Protective Co. 1104
Medicenter of America, Inc. 1105
Mercywood Hospital 1089
Michigan State Medical Society 1059
Moore Publishing Co. 1089
Robins, A. H. Co. 1085, 1086, 1087, 1094, 1095
Roche Laboratories . . . . . Cover IV
Searle, G. D. and Co. 1080, 1081
Schering Corp. 1102, 1103
Smith, Kline and French Labs. 1082
Stratton, Ben P. . . . . . Cover II
Walker Corp. and Co. 1092, 1093

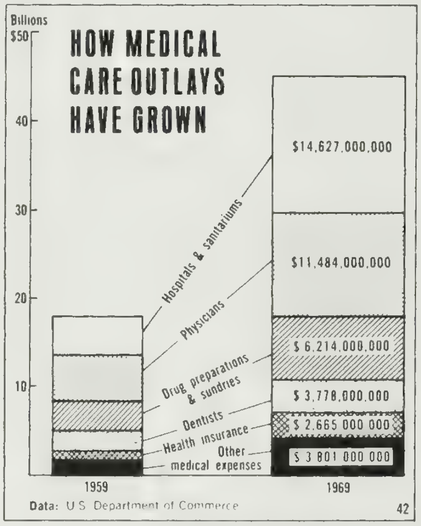
noted and quoted

BY HERB AUER, EXECUTIVE EDITOR

The county and state medical societies and the AMA are described as "Keepers of our professional flame," by Missouri State Medical Association President Joseph L. Fisher, MD, in a recent issue of *Missouri Medicine.* Doctor Fisher wrote, "only through organized medicine and, especially, the AMA, can we present a united approach to our legislative problems. If the physicians of this country plus 100,000 dentists, plus 75,000 pharmacists, plus 50,000 veterinarians, plus 500,000 nurses would work together arm-in-arm at the ward and precinct levels, much assistance could be given in electing the type of legislators this country needs to preserve the freedoms we have known, the freedoms which have enabled our people to make this the greatest country in the history of man."

* * *

Have seen this graph prepared by the Chamber of Commerce in a number of association publications. The graph shows that people are spending more on all forms of health care services. There are many reasons for the rising demand for health care: the population is growing . . . incomes generally are up . . . people are better educated to medical needs . . . more people live in cities where medical care is available . . . health insurance offers broader coverage . . . new scientific techniques improve the diagnosis and treatment of illnesses, etc. Rising wages of the many, many health workers has caused health care to be more expensive— while it certainly is more effective. Total consumer outlays for medical services rose from $18 billion in 1959 to almost $43 billion in 1969; and per capita outlays for health rose from $101 to $209. Rising medical costs may be slowed down through increasing the supply of medical personnel and by increasing the efficiency of health facilities.



CHAMBER OF COMMERCE OF THE UNITED STATES

State Supt. of Public Instruction, John W. Porter recently suggested that the ABC's of education today stand for "accountability, bargainability, comparability." "These are the real big issues that I see in the next 10 years," he added.

Doctor Porter reported that the first state assessment of student accomplishment "confirmed data that we already knew . . . in our urban centers the students do not achieve as well as they do in the rural areas or as well as they do in the suburban areas."

He suggested that one of the biggest faults among educators is that "there is an undeniable confusion between means and ends and unfortunately we spend an inordinate amount of time debating and arguing the differences betweeen means when normally the ends aren't that far apart."

* * *

"Spending more money alone is not the answer," the National Chamber of Commerce Special Committee on the Nation's Health Care Needs agreed after initial meetings of the new task force. The *Washington Letter* publication of the National Chamber reports that the Committee sees, "One of the most serious problems is the need for structural changes in delivery of personal health care services, and the need to provide incentives for health preventive and maintenance services while building on the freedom of choice for both health care personnel and the American user of such services."

* * *

Various component medical society bulletins carry articles about the House of Delegates each fall. President Ralph F. Askam, MD, of the Muskegon County Medical Society, in his message in the October issue of their Bulletin wrote in part, "It has been my impression that 3 days at the House of Delegates is a classic example of how so few can do so much—to or for so many and in so little time."

* * *

Medical society leaders were challenged at the 1970 AMA Communications Institute "to become leaders in change and not reactors to change."

Walter H. Johnson, Jr., chairman of the board of Myers-Infoplan, New York City, suggested that doctors need to better understand the changes going on today. "Doctors fail to anticipate change,' said Mr. Johnson, whose firm han dles PR work for the AMA ir New York City.

He listed these factors influenc ing change — government, popula tion, youth, humanism, education innovation, information, commu nication, competition, environ ment and social progress. He rec ommended that, "medicine need dialogue with social scientists."

Breaking News: Deadline December 10
December 1970, Volume 69, Number 24
Michigan State Medical Society

michigan medicine

U. C. SAN FRANCISCO
MEDICAL CENTER LIBRARY

JAN 8 1971

MSMS House, In Special Session, Declines to Elect Representatives to New Blue Shield Body

The Michigan State Medical Society House of Delegates in special session Dec. 16 declined to exercise its privilege to elect 15 official MSMS representatives to the new, restructured Blue Shield corporate body and also voted that MSMS officers and councilors be instructed not to serve as ex-officio members of the corporate body.

MSMS members at their annual session in Detroit in September relinquished its majority voice in the Blue Shield corporate body.

The revised articles of incorporation provided two alternative ways for electing 15 Michigan doctors of medicine to the new corporate body—and now the chairman of Michigan Blue Shield will make the appointments following the vote by the MSMS house 46-35 to decline the first option.

Physicians will still serve on the corporate body and the board but simply will not be there as "official" representatives of the medical society. Any member of MSMS is free to serve if he or she wishes in the corporate body or on the board as an individual provider of physician services.

Doctor Hamburg, Doctor Andrews, Doctor Wilson Elected to MSMS Judicial Commission

Three new members of the MSMS Judicial Commission have been elected by ballots cast in the first, fifth and seventh districts. They are Robert H. Hamburg, M.D., Detroit; Sherman E. Andrews, M.D., Kalamazoo, and George M. Wilson, M.D., Marquette.

Doctor Hamburg will represent physicians in Wayne County, while Doctor Andrews will speak for those in southwest Michigan and Doctor Wilson for those in the Upper Peninsula and northern lower peninsula.

WSU Annual Symposium on Blood Jan. 22-23

Designed to appeal to all physicians regardless of specialty, Wayne State University's 19th Annual Symposium on blood Jan. 22-23 will explore developments in "Thrombolytic Therapy," a new approach to the treatment of thromboembolic diseases.

The WSU Departments of Physiology and Pharmacology in the School of Medicine are sponsoring the two-day meeting at the WSU McGregor Memorial Conference Center. Registration may be made through Eberhard F. Mammen, M.D., professor of physiology and pharmacology and pathology, WSU School of Medicine, 1400 Chrysler Freeway, Detroit 48207.

MARMP Elects Dorothy Carnegie, D.O., To Succeed Doctor Marshall

The Michigan Association for Regional Medical Programs has a new board of directors and president of that board.

She is Dorothy Carnegie, D.O., Lansing, and is also president-elect of the Michigan Association of Osteopathic Physicians and Surgeons. Doctor Carnegie succeeds Don Marshall, M.D., Kalamazoo, who resigned.

New MARMP vice president is Ethelene Crockett, M.D., Detroit, president of the Wolverine Medical Society; while Andrew D. Hunt, Jr., M.D., East Lansing, dean of the Michigan State University College of Human Medicine, is secretary-treasurer.

Other members of the seven-man board of directors are John Gronvall, M.D., Ann Arbor, acting dean of the University of Michigan Medical School; Mr. William McNary, Detroit, executive secretary of the Greater Detroit Area Hospital Council; Gerald Rice, M.D., director of Michigan Bureau of Maternal and Child Health, and Allen Zieger, D.O., of the Zieger-Botsford Hospitals of Farmington.

In other recent MARMP action, the Regional Advisory Group reelected Michael Brennan, M.D., Grosse Pointe, as chairman. MARMP has been awarded a total of $1,901,050 for the program year ending Aug. 31, 1971.

Michigan Health Council Elects Win Schuler

Win Schuler of Marshall is the new president of the Michigan Health Council. He was elected the 18th MHC president at the annual meeting recently at Towsley Center, The University of Michigan.

Serving with him are William Hennessy, R.Ph., Grosse Pointe, president-elect; F. Darl Ostrander, D.D.S., Ann Arbor, immediate past president; Harry A. Towsley, M.D., Ann Arbor, president emeritus; Hugh W. Brenneman, East Lansing, secretary; John C. McCabe, Detroit, treasurer; Robert Rice, M.D., Greenville, medical advisor; Marvin L. Niehuss, Ann Arbor, legal advisor, and John A. Doherty, executive vice president and assistant treasurer.

Harry A. Towsley, M.D., Ann Arbor, was elected to the Health Council's hall of fame for his efforts in improving postgraduate medical education and the health of babies and children. Hugh W. Brenneman, East Lansing, received the 1970 Community Health Week Award for his efforts in improving health education through radio, television and the news media.

Experimental Wayne County Program To Provide 30,000 Free Pap Smears

Jan. 18 is the starting date for an experimental program in Wayne County which will provide free Pap smear tests for 30,000 women the first year. The tests will be given in three permanent buildings in the high-risk area of the county, provided by the Michigan Cancer Foundation in cooperation with Wayne State University.

All suspicious cases will be checked. If surgery is needed, it will be provided by WSU on a no-fee basis if necessary. The experiment will be preceded by an educational program.

Two Documents on Sex Education Guidelines Available at MSMS Headquarters

The two major documents in the development of guidelines for the teaching of sex education and family planning in Michigan's public schools are available to interested physicians from MSMS Headquarters.

The documents are the report of the State Board of Education's Advisory Committee on Sex Education and Family Planning Information in Michigan's Schools, made in June, 1969, and the August, 1970, "Sex Education and Family Information Guidelines for Local Public Schools Choosing to Conduct a Sex Education Program," as distributed by the State Board of Education.

Both sets of guidelines have been reviewed by the Committee on Lay Education (Subcommittee of the MSMS Committee on Maternal and Perinatal Health), which recommends use of the June, 1969 guidelines.

Public Hearings Set Dec. 29-30 On Blue Cross-Blue Shield Rate Increases

State Insurance Commissioner Russell E. Van Hooser has announced public hearings to be held in Detroit on Dec. 29 and in Lansing on Dec. 30 on rate increase applications filed by Michigan Blue Cross and Michigan Blue Shield for the second quarter of 1971.

Blue Cross has asked for increases in base rates averaging 9.6 per cent for the various categories of contracts it offers. Blue Shield asked for approval to increase base rates an average of 5.9 per cent for the various contracts it offers.

Van Hooser said the proposed base rate schedules are designed to establish the income level for both Blue Cross and Blue Shield. Public hearings are held each quarter to give the public an opportunity to discuss the merits of any proposed adjustments in Blue Cross and Blue Shield rates.

Family Practice Review Course Jan. 18-22 at The U-M

The Michigan Academy of General Practice and the University of Michigan Department of Postgraduate Medicine are co-sponsoring a Family Practice Review Course Jan. 18-22 at Towsley Center, the U-M Medical Center.

Enrollment forms for the program, scheduled from 8 a.m. to 5 p.m. each day, are available from the U-M. The course has been approved for 40 prescribed credit hours by the American Academy of Family Physicians, and will be taught by members of the U-M medical faculty and practicing generalists.

Here are three more excellent pamphlets produced by the American Medical Association and designed to help the physician in his contacts with the public and his patients:

________"Make the Most of Your American Medical Association," an eight-page pamphlet briefly listing the AMA's services and materials, its purposes and responsibilities.

________"Your Friend the Doctor," a full-color booklet written for children, describing a visit to the doctor, listing food health practices, and including a picture story and short glossary of health terms.

________"Facts on Quacks," a 32-page booklet for the public detailing "what you should know about health quackery."

Laurence A. Kater, Shaker Heights, Ohio, left, Michigan State University medical student, discusses his research with a faculty adviser, Donald H. Kuiper, M.D., assistant professor of medicine. Kater won the 1970 medical student research award of the regional chapter of the American Federation for Clinical Research.

Capsules

About 50 persons, among them official representatives of county medical societies, have been invited to attend a workshop on population control scheduled all day Jan. 28 at MSMS Headquarters. Sponsoring the workshop is the MSMS Committee on Maternal and Perinatal Health. Francis A. Locke, M.D., Adrian, is workshop chairman.

* * *

The 1969-70 annual report by the Michigan Association for Regional Medical Programs will be included in the January issue of *Michigan Medicine* in a special eight-page insert. The report will include a message from the immediate past president of MARMP, Don Marshall, M.D., Kalamazoo.

* * *

A special family winter weekend and scientific meeting is planned Jan. 22-24 at Shanty Creek Lodge, Bellaire, by the Michigan Allergy Society. Richard S. McCaughey, M.D., and Hector L. Mulero, M.D., both of Wayne State University, will discuss "Gastrointestinal Syndromes which Mimic Gastrointestinal Allergy," at the Saturday evening program.

* * *

Maurice Tatelman, M.D., Detroit, is new president of the former Detroit Roentgen Ray Society, which is now the Michigan Radiology Society. Other new officers are Kenneth L. Krabbenhoft, M.D., Detroit, president-elect, and David P. Corbett, M.D., Harper Woods.

---

michigan medicine

MICHIGAN STATE MEDICAL SOCIETY

Published semi-monthly, Trimonthly in December; 25 issues, by the Michigan State Medical Society as its official journal. Second class postage paid at East Lansing, Mich. and at additional mailing offices. Yearly subscription rate, $9.00. Printed in USA. All communications should be addressed to the Publications Committee, Michigan State Medical Society, 120 West Saginaw Street, East Lansing, Michigan 48823. © 1970 Michigan State Medical Society. Phone: Area Code 517, 337-1351.

Second Class Postage Paid at East Lansing, Mich.
and at additional mailing offices.

UNIVERSITY OF CAL
LIBRARY SCH OF MED
THIRD & PARNASSUS AVE
SAN FRANCISCO CAL 94122

Attention Librarians: This publication is a regular issue of MICHIGAN MEDICINE and should be saved for binding later with the larger scientific issues of the journal.

michigan medicine

U. C. SAN FRANCISCO
MEDICAL CENTER LIBRARY
JAN 28 1971

DIGEST OF PROCEEDINGS 1970 HOUSE OF DELEGATES

Michigan State Medical Society
December 1970, Volume 69, Number 25

1970 House of Delegates Proceedings
105th Annual Session
Michigan State Medical Society

How to Use This Digest

For convenient use of the *Digest of Proceedings,* the following procedure has been used:

Each report is followed immediately by the action of the reference committee on that report and then by the House action on the report of the reference committee. Resolutions are printed as they were finally adopted or disapproved by the House.

Table of Contents

Page

Call to Order and Special Reports

Call to Order 5
Invocation 5
Report of Credentials Committee 5
Report of Committee on Rules and Order of Business 5
Speaker's Remarks 5
President's Address 9
President-Elect's Address 10
Treasurer's Report 11
Report of Michigan Delegation to the American Medical Association 12
Report of Woman's Auxiliary 15
Report of the Michigan State Medical Assistants Society President 16
Annual Report of Michigan Blue Shield 17
Remarks of Spokesman for Medical Students 19

Reports of The Council

Remarks of The Council Chairman 20
Report of Council Activities 22

Committee Reports

Annual Summaries of Council Committees:

Alcohol and Drug Dependence 31
Courses on Medical Economics and Ethics 31
Education Liaison 31
Emergency and Disaster Medical Services 32
Eye Care 32
Group Travel Plans 32
Health Problems of the Disadvantaged in the Cities 32
Hospital Relations 32
International Health 32
Liaison with Michigan Chapter of Health Insurance Council 33

Page
Liaison with Michigan State Pharmaceutical Association 33
Liaison with Podiatry 33
Liaison with Residents, Interns, Senior Medical Students 33
Liaison with State Bar of Michigan 33
Liaison with State Board of Registration in Medicine 33
Liaison with State Executive Office 33
Medical Aspects of Organized Athletics 33
Medicine and Religion 34
Nursing 34
Relative Value Study 34
Rehabilitation 34
Utilization Review and Health Insurance Problems 34

Annual Summaries of Standing Committees:

Advisory to Michigan State Medical Assistants Society 34
Advisory to Woman's Auxiliary 35
Cancer 35
Cardiac Disease Control 35
Child Welfare 35
Governmental Medical Care Programs 36
Highway Injury 36
Hospital Privileges 36
Legal Affairs 37
Maternal and Perinatal Health 37
Medical Socio-Economics 38
Mental Health 38
Michigan Medical History 38
Occupational Health 38
Postgraduate Medical Education 39
Professional Insurance Plans 39
Public Health 39
Public Relations 39
Rural Medical Services 40

Reports of House of Delegates Committees:

Certificates of Commendation 40
Compensation of Officers 42
Constitution and Bylaws 43
Procedures of the House of Delegates 44
Relationship of Specialty Societies in the House 44
Nominating Procedures of the House 44

Resolutions

1. Shortage of Physicians 45
2. Reduce the Premedical Requirements for Matriculation in Medical Schools 45
3. Urge Michigan Medical Service (Blue Shield) to Adopt and Use *AMA CPT, '70 Edition* 45
4. Divestiture of Control of Blue Cross-Blue Shield Program 45
5. Michigan Blue Shield 46
6. Change Health Insurance Contract for Members and their Employees 46
7. Encouragement of Family Practice & Improved Physician Distribution 46
8. M.D. of the Week Program 46
9. Temporary Registration of Medical Doctors 46
10. Establishment of Counselling Service—Medical Socio-Economics 47
11. Adoption of Relative Value Guide by Blue Shield 47
12. Component Medical Societies Liaison with State Legislators 47
13. Incentives to Practice in Areas of Need 47
14. Election of AMA Delegates 47
15. Multiple Methods of Practice 47
16. Merger—Medical Social Economics Committee and Governmental Affairs Committee 48

Page

17. Health Examinations for Athletes 48
18. Individual Case Participation 48
19. Non-Participating Physicians of Blue Shield 48
20. Preservation and Restoration of Great Lakes 48
21. Ambulance Personnel Training 49
22. Approval of Radiation Health and Safety Act of 1970 49
23. Professional Standards for Athletic Trainers 49
24. Appointment of Certified Athletic Trainers (Athletic Health Coordinators) 49
25. Support of the Governor's Proposal for Control of Drug Abuse 49
26. Public Educational Programs on Drugs 49
27. Postgraduate Training Programs on Drug Abuse and Drug Dependence ... 50
28. Medicaid Allowance for Immunization 50
29. Maldistribution of Physicians 50
30. Coordination of Various Governmental Medical Care Programs 50
31. Reaffirmation of Michigan State Medical Society Policy Statement on Abortions 50
32. Hospital Facilities for Drug Dependence 50
33. Mediation of Physician-Hospital Disputes 50
34. Necessity of Postgraduate Study 51
35. Division of Legislative and Executive Functions 51
36. Opposition to Anti-Substitution Repeal 51
37. Reimbursement of Michigan Medical Service Board Members 51
38. Continuation of MD Volunteer Lobbying Program 51
39. Objection to Reimbursement of Chiropractors in Federally-Funded Health Programs 51
40. Printing of MSMS Directory of Members 52
41. Councilor for Oakland County 52
42. Extra Meeting of MSMS House of Delegates 52
43. Drug Control 52
44. Malpractice and the Contingency Fee 52
45. Rehabilitative Care 53
46. Establishment of Socio-Economic Department 53
47. Establishment of Socio Economic Department 53
48. Drug Intoxication and/or Addiction: A Disease 53
49. Uniform Billing Practices 53
50. Medical School Departments of General Practice 53
51. Formation of the Michigan State Hospital Staff Association 53
52. Establishment of Priorities for the Expenditure of MSMS Funds 54
53. Responsibility of Physicians Accepting Third Party Payments 54
54. The Patient's Right to Choose Manner of Payment 54
55. Dissolution of the Corporate Relationship of Michigan State Medical Society to Blue Shield 54
56. Disposal of Disposables 54
57. Third-Party Default by Delay of Payment or Arbitrary Reduction of Fees 54
58. To Produce More Physicians 55
59. Defense of Michigan Doctors 55
60. Dissatisfaction with the Operational Effectiveness of Michigan State Medical Society 55
61. MSMS Relationship with Outside Groups, Associations, Corporations, Governmental Units or Other 55
62. National Health Plans 55
63. Composition of State Comprehensive Health Planning Advisory Council ... 56
64. Commendation to Michigan Comprehensive Health Planning Advisory Council 56
65. Increase State Funds for Alcohol Programs 56
66. Abolishment of Regional Screen Variation in Reimbursement by Blue Shield 56
67. Compensation for Medical Service in Extended Care Facilities 56
68. Bylaw Amendment for Membership Transfers 57
69. Guidelines for Funds Derived from the Supervised Care of Staff Patients .. 57
70. Socio-Economic Department 57
71. Chiropractic 57
72. Disassociation of MSMS from Michigan Blue Shield 57

Page
73. Civil Prosecution of Individuals Associated with Possession or Transmission of Narcotics and Dangerous Drugs 57
74. Privilege of Minors to Give Consent for Examination 58
75. Support of the Governor's Proposal for Control of Drug Abuse 58
76. Business Relationships Between Michigan Medical Service and Professional Corporations 58
77. Association Between MSMS and Michigan Blue Shield 58
78. Proposed Michigan Blue Shield Amendment to its Articles of Incorporation 58
79. Relationship of Blue Shield and MSMS 58
80. Physician Staffing of Blood Donor Clinics 59
81. Preparation of Contractual Fee Schedule for Governmental Agencies 59
82. Payment of Physician Charges by Credit Cards 59
83. Repeal of Basic Science Act 59
84. Pilot Program of Baccalaureate Study Physician Assistant 59
85. Establishment of a Family Practice Department 59
86. Conference on Maternal and Perinatal Health 59
87. Smoking During Meetings of House of Delegates 60
88. Michigan Medical Service Board of Directors 60
89. 30 Years In, Out with $500 per Month 60
90. Establishment of Negotiating Agents 60
91. Increased Allocations for Medical Schools 60
92. Opposition to Contingency Fee System in Malpractice Cases 60
93. Opposition to Anti-Substitution Repeal 61
94. Drug Abuse & Minors Consent 61
95. Voluntary Elective Sterilization 61
96. Encouragement of Family and Rural Practice 61
97. The Multiplicity of Hospital Inspections 61
98. AMA Delegates to be Ex-Officio Members of The Council 62
99. Support of Michigan Medical Service Plan 62
100. Medical Foundations 62
101. Medicare Home Health Services 62
102. Change of MMS Service Policy to Indemnity Policy 62
103. Greater Cooperation with Michigan Hospital Association 63
104. Hospital Committee on Efficiency 63
105. Educational Program on Crime and Delinquency 63
106. Professional Liability Legislation 63
107. Michigan State Medical Society Opposition to Bennett Amendment 63
108. New Pictures for MSMS House of Delegates Leaders 64
109. SAMA Representation in the House of Delegates 64

Presentations and Awards

Special Memberships 64
Fifty Year Awards 64
National Presidents Awards 65
MSMS Special Awards 65
MSMS Flag Awards 65
MSMS Awards to Physician of the Week 65

Elections 65

Reference Committee Personnel 66

Delegates—Record of Attendance 67

Michigan State Medical Society
105th Annual Session
September 20-22, 1970

CALL TO ORDER AND SPECIAL REPORTS

1. Call to Order

The House of Delegates of the Michigan State Medical Society, held at the Sheraton-Cadillac Hotel, Detroit, Michigan on September 20-22, 1970, convened at 8:30 pm, J. B. Blodgett, MD, Speaker and Vernon V. Bass, MD, Vice Speaker, presiding.

2. Invocation

The Speaker called upon R. R. Cooper, MD, to give the invocation.

3. Report of Credentials Committee

Chairman B. D. Bauer, MD, reported 137 Delegates seated, the majority of whom were not from any one county.

4. Report of Committee on Rules and Order of Business

Chairman F. B. Walker, MD, reported that the Committee on Rules and Order of Business has thoroughly reviewed the order of business as printed on the first divider in the delegates' handbook. We approve of the order of business, particularly No. 22 thereof which specifies that resolutions may not be introduced after the second meeting of the House, Monday morning, September 21, except by consent of two-thirds of the seated delegates.

Further, your Committee wishes to recommend to the House of Delegates that resolutions dealing with the continued relationship between MSMS and Blue Shield be referred to a single reference committee with instructions to have its report available by 8 p.m. Monday, September 21, 1970.

The Committee notes that Mr. Stewart Kerr, Legal Counsel of the Michigan State Medical Society, has again been designated to perform the important duties of Parliamentarian. Recalling the excellence with which he filled this post during the 1969 Annual Session, the Committee heartily approves.

Fourth, Mr. Speaker, your Committee wishes to again recommend to the House of Delegates, as it did in 1969, that the House vest in the Speaker the authority to recess its proceedings to a time certain, at his discretion, and without the necessity of the vote of the body. Such vesting of authority will constitute the only departure from Robert's Rules of Order, which we recommend otherwise govern the proceedings of the 1970 House of Delegates.

The report was adopted.

5. Speaker's Remarks — J. B. Blodgett, MD

The Speaker outlined the plans and procedures of the House and introduced special invited guests.

(The following report of the Speaker was presented to the delegates in printed form.)

This is a brief review of the implementation of resolutions adopted by the 1969 House of Delegates. (For complete text of resolutions with House action, refer to the Digest of Proceedings, *Michigan Medicine,* Vol. 68, No. 26, December, 1969.)

Summary:

A. Resolutions adopted:

1. Legislative—4, 14, 30, 35, 40, 45, 46, 47, 48, 62, 63, 65, 70, 74
2. Blue Shield—2-9-11-21-29-67, 12 13, 16, 24-26, 28, 32, 44-64-81, 49, 66, 82-83, 84, 85, 86
3. Committees—8, 20, 41, 42, 51, 54, 60, 69, 77, 78, 80
4. General Business—1, 3, 5-43-53-73, 7, 10, 13, 17, 19, 22, 23, 25, 27, 33, 34, 39, 50, 55, 56, 61, 68, 71, 88

B. Resolutions disapproved or no action—6, 18, 31, 36, 37, 38, 52, 57, 58, 59, 72, 75, 76, 79, 87

Res. 1 — Michigan's Outstanding Physician. This resolution directed that the practice of designating "Michigan's Outstanding Physician" be discontinued, but the program of awarding certificates of commendation or meritorious service awards be continued. This has been implemented for the 1970 House of Delegates.

Res. 2 — Blue Shield "Over-the-Screen" Letters. Resolutions 2, 9, 11, 21, 29 and 67 were considered together and a substitute resolution requested that Blue Shield's report to the patient of the non-participating physician be limited to a statement accompanying the payment stating that the payment represents the financial obligation of Blue Shield in this service.

Blue Shield discontinued the "over-the-screen" letter by November 15, 1969. An interim system of handling over-the-screen cases, called "Alternative A" was in effect from November to February 20, 1970 at which time a new pay Subscriber DSR was introduced.

Res. 3 — Physician Examinations for Colleges and Universities. This resolution directed that MSMS develop and offer, as a public service, a standardized physical exam for all colleges and universities. The resolution has been referred to committee for investigation and study in conjunction with the medical departments of the major universities.

Res. 4 — Provision of County Health Authority. This resolution directed that MSMS support the concept of a county health authority where appropriate, and outlined the ratio of physician members of such authorities. It also directed that the need for legislation to permit such authorities be studied.

The Council referred the resolution to the Committee on Legal Affairs for consideration. A survey conducted with the help of the Department of Public Health indicated that the introduction of legislation was warranted. The Council approved the recommendation of the Legal Affairs Committee that a bill be introduced in the 1971 Legislature providing that at least one physician (MD or DO) be a member of all county or district boards of health, and such a bill is being prepared for introduction.

Res. 5 — MSMS Advisory Committee on Provision of Health Care Services. This substitute resolution instructed The Council to develop a competent counseling service for itself, MSMS members and component medical societies. The Council directed that the Committee on Medical Socio-Economics develop such a plan and submit it to the Finance Committee for consideration of the costs involved.

The Medical Socio-Economics Committee, in conjunction with the Public Relations and Governmental Medical Care Committees, is now in the process of improving a detailed plan and cost estimates following suggestions of the Finance Committee.

Res. 6 — Active Membership in MSMS for DOs. This resolution was disapproved by the House.

Res. 7 — School and Health Physical Examinations for Interscholastic Athletics. This resolution urged adoption of a policy by the Michigan High School Athletic Association which would require only one physical examination each at the junior and senior high school levels.

The Council referred this resolution to the Committee on Medical Aspects of Organized Athletics. In discussing this matter with the Michigan High School Athletic Association, the Committee recognized the value of continuing annual examinations and recommended to The Council that no action be taken on the resolution, and that introduction of a countermanding resolution in the 1970 House of Delegates be encouraged. The Council approved the Committee's recommendation.

Res. 8 — Medical Service to Needy Areas in Michigan. This resolution directed that an appropriate MSMS committee assist in development of programs encouraging students, interns and residents to serve in needy areas following completion of their training.

The Council referred this resolution to the Committee on Health Problems of the Disadvantaged for appropriate implementation. Subsequently, the committee was disbanded, and its responsibilities were assumed by the Committee on Medical Socio-Economics, which now has this resolution under consideration.

Res. 9 — Blue Shield Plan Procedure. (Substitute adopted, see Resolution 2 above.)

Res. 10 — Abolishing Contingency Fees in Malpractice Actions. This resolution officially stated MSMS opposition to contingency fees. It was transmitted to the appropriate committees for their use in dealing with relevant topics.

Res. 11 — Withdrawal of Blue Shield Letter. (Substitute adopted, see Resolution 2 above.)

Res. 12 — Division of Blue Shield-Blue Cross Premium. This resolution requested Blue Shield to devise a method of informing subscribers of premium division. The Blue Shield Board reported that this resolution could not be implemented because of the following reasons: quarterly rate filings and changes pose substantial practical problems, because Blue Shield certificates and billing notices are communicated by groups to their own members rather than by MMS, and finally because of cost implications.

Res. 13 — Election of Delegates and Alternates to AMA. This resolution directed the Speaker to appoint a committee to study the method of nominating all elective officers of the House. (See Report of the Committee to Study Nominating Procedures, which is being submitted directly to the House of Delegates.)

Res. 14 — Michigan's Abortion Laws. This resolution reaffirmed MSMS policy that the Michigan Criminal Code should not apply to abortions performed in licensed and accredited hospitals by licensed MDs and DOs.

MSMS has continued efforts to support proposed abortion reform throughout the year. The Michigan Senate failed to pass an abortion reform bill during this session, but interested groups such as MSMS will continue to urge reform according to the House directive.

Res. 15 — Care of the Newborn. This resolution requested Blue Shield to provide care of the newborn infant throughout the period of hospitalization regardless of who attended at delivery. Blue Shield reported that because of current charging practices of physicians in this area, the existence of benefit for the new-born ill child, the likelihood of a well-baby care benefit being included in the near future and the impact on liability that implementation of this resolution was not feasible.

Res. 16 — Payment for Regional Anesthesia. This resolution requested Blue Shield to pay for major nerve block, spinal, saddle, caudal and local intravascular anesthesia when rendered by a physician along with obstetrical or surgical procedures, regardless of the availability of an anesthesiologist.

Blue Shield reported that primarily because current charging practices of physicians are still inclusive of this service, and because of the impact on liability and inasmuch as a change in the contract language would be required that implementation of this resolution was not feasible.

Res. 17 — MSMS Stand on Chiropractic. This resolution reaffirmed MSMS stand that the practice of chiropractic is an unproved cult and decried the unfounded advertising claims of this cult. It was transmitted to the appropriate committees for their information.

Res. 18 — Study of Research in Manipulation. This resolution was disapproved by the House.

Res. 19 — Amalgamation of Osteopathy and Medicine. This resolution reaffirmed the position favoring amalgamation with osteopathy as being in the best interests of the future of medical practice and therefore the health of all. The House referred the resolution to The Council for study. The Council referred the subject to the Committee on Medicine and Osteopathy which was disbanded without considering the resolution. The resolution has not been referred to another committee at this time.

Res. 20 — Water Pollution. This resolution dealt with the problems of water pollution as a health hazard and directed the Michigan delegates to the AMA to introduce an appropriate resolution at the next session of the AMA House of Delegates. The Michigan delegation introduced a resolution, "Promoting Environmental Health" at the November 1969 session, which was adopted.

The resolution also directed the Committee on Public Health to work closely with the Michigan Department of Health to implement and expedite the use of the previously voted funds for the correction of water pollution. The Committee, through its close liaison with the Department, participated in several conferences in the Great Lakes area dealing with the most appropriate expenditure of funds in controlling water pollution.

Res. 21 — Blue Shield Letter. (Substitute adopted, see Resolution 2 above.)

Res. 22 — Councilor Districts for Medical Schools. This substitute resolution encouraged medical school faculty members to become active in MSMS affairs, and further directed that representatives of each school continue to be invited to attend meetings of The Council. The Council has continued during the past year its previous policy of inviting the deans to attend Council meetings. The resolution was also transmitted to the deans for their information.

Res. 23 — Physical Fitness. This resolution endorsed MSMS cooperation with recognized physical fitness and health programs. The resolution was referred to the Committee on Public Relations which continues to publicize newsworthy events on physical fitness programs.

Res. 24 — Blue Shield Premiums and Fees. Resolutions 24 and 26 were considered together and a substitute resolution was offered which requested Blue Shield to study premiums and fees to insure that the four socio-economic areas are equitable for all concerned. Blue Shield reported that it felt that the division of the state into four socio-economic areas was equitable at this time, but that periodic review of the matter was planned.

Res. 25 — Endorsement of George R. Herrmann, MD, for the Distinguished Service Award of AMA. This resolution directed the Michigan delegation to the AMA to participate with the Texas delegation in endorsing the nomination of Dr. Herrmann for the Distinguished Service Award. The Texas delegation was to submit the nomination to the AMA Board of Trustees but indicates that they have tentative plans to do so at the 1970 Interim Meeting in Boston.

Res. 26 — Inequity of Prevailing Fees Under MVF. (Substitute adopted, see Resolution 24 above.)

Res. 27 — Orientation of New and Potential Members of MSMS. This resolution directed that component medical societies be responsible for indoctrination of new members, that medical schools be encouraged to include organizational medicine in the curriculum, and that a certificate of membership for new members be designed.

The resolution was transmitted by letter to the component medical societies and they were urged to develop such orientation programs. The Education Liaison Committee brought the requested curriculum changes to the attention of the deans by letter. All replies indicated interest in covering such subjects at the first-year level and expressed willingness to experiment further.

A membership certificate has been developed and is being presented to new members of the Society, beginning in July 1970.

Res. 28 — Blue Shield Conformance with 1969 AMA House of Delegates Action. This resolution requested Blue Shield to conform with the 1969 AMA Resolution 37 which states that under each program the terms 'usual, customary or reasonable' be properly defined and agreed upon by the physicians, the beneficiaries and the insurance carriers as developed by local determination so far as a physician's participation is concerned, and further that any reference to 'paid-in-full' coverage clearly identify those services which are covered and the circumstances under which those services must be rendered.

The Board of Blue Shield reported subsequently that they were essentially in compliance with the AMA recommendation.

Res. 29 — Clarification of MSMS Position Concerning Insurance Carriers. (Substitute adopted, see Resolution 2 above.)

Res. 30 — School Bus Safety. This resolution favored improved legislation to insure school bus safety. The resolution was transmitted to appropriate leaders of the Michigan Senate and House of Representatives, inviting them to review and improve school bus safety requirements. The resolution was also transmitted to the Highway Injury Committee for continuing study and recommendation.

Res. 31 — Survey of Michigan Physicians re Malpractice Problems. This resolution was disapproved by the House since the intent of the resolution would be accomplished by the implementation of the reports of the Committee on Professional Liability Insurance. (See Part II of the Annual Report of The Council.)

Res. 32 — Individual Case Participation. This resolution reaffirmed MSMS' strong support of individual case participation. Blue Shield reported that its executive committee considered the issue and recommended the qualified continuance of per-case participation at its meeting of July 22, 1970.

Res. 33 — Reserved Seats for Council Members. This resolution directed that suitable facilities be provided for members of The Council at all meetings of the House of Delegates and the directive will be implemented at the 1970 meeting.

Res. 34 — Bylaws Provision for Active Dues Exempt Membership Status. This resolution amended the Bylaws to exempt persons in post-graduate study or approved residencies from dues in MSMS if also exempted by the county medical society. The exemption was incorporated into the September 1969 revision of the MSMS Constitution and Bylaws as Section 9 of Chapter 5.

Res. 35 — Inclusion of Compulsory Examinations in Payment Schedule of Medicaid. This resolution directed that MSMS encourage the appropriate governmental agencies to include such compulsory examinations under the payments schedule with Medicaid for Medicaid beneficiaries. A letter was written to the director of the Department of Social Services asking for inclusion of all compulsory child physical exams as a Medicaid benefit.

Res. 36 — Requirement of "Good Faith" Deposit with Court in Malpractice Actions. This resolution was disapproved by the House.

Res. 37 — Committee to Consult on Harm of Criminal Use of Drugs to Human Body. The House took no action on this resolution, feeling that the existing MSMS Committee on Alcohol and Drug Dependence already serves the purpose of the resolution.

Res. 38 — Regional Advisory Committees to Blue Shield. This resolution was disapproved by the House.

Res. 39 — Communications Between the Membership of MSMS and AMA and Their Representatives. This resolution requested The Council to make every effort to expedite the transmission of information of interest to the MSMS delegates. The Council has expanded as directed the information on Blue Shield and financial matters contained in its minutes.

Res. 40 — Ambulance Problems. This resolution requested introduction of legislation calling for two attendants on all ambulances and increased ambulance attendant training in cardio-pulmonary resuscitation. This resolution was referred to the Legal Affairs Committee, who after discussion, recommended that the resolution should be implemented by local action and not state law so that available resources could be appropriately utilized. The Council subsequently approved the recommendation.

Res. 41 — General Practice in Medical School Curriculum. This resolution directed that medical schools be encouraged to adequately instruct students in general practice, and it was referred to the Committee on Education Liaison. The Committee communicated this request to the three medical schools and all replied reporting their efforts to increase exposure to the concept of family practice.

Res. 42 — Support for Sound Guidelines for Teaching Sex Education. This resolution was referred to the Committee on Maternal and Perinatal Health for study and issuance of a concise position statement. The House further directed that the Committee report to The Council, by January 1970, its recommendations on the guidelines for sex education in the schools. The Council received the position paper, "The Teaching of Sex Education" at its January meeting.

Res. 43 — Assumption of a More Active and Effective MSMS Role in the Socio-Economics of Modern Medicine. (Substitute adopted, see Resolution 5 above.)

Res. 44 — Study of Discontinuance of MSMS Relationship with Blue Shield. Substitute Resolution 44 directed that a full study be made of all aspects, favorable and unfavorable, with all the ramifications of the feasibility of discontinuing the MSMS historical relationship with Blue Shield. The Council referred this matter to the Task Force on MSMS Structure for consideration. (See Report of the Task Force, which is being submitted directly to the House of Delegates.)

Res. 45 — Participation in Comprehensive Health Planning. This resolution urged MSMS members to actively participate in comprehensive health planning and encouraged active physician participation on local health planning committees. It was transmitted to the appropriate committee for information.

Res. 46 — Arbitrary Health Facilities Guidelines. This resolution directed that the Governor be asked to disapprove mandatory use of Hill-Burton criteria and/or the Hill-Burton state plan by areawide comprehensive health planning councils. The Governor was so urged by letter.

Res. 47 — Appeals From Comprehensive Health Planning Decision. This resolution determined to ask the Governor of Michigan to make the State Comprehensive Health Planning Advisory Council the appeal board for decisions made by area-wide health planning councils and the Michigan State Comprehensive Health Planning Commission itself. The Governor was advised of this position and the request was implemented through Executive Order on January 15, 1970.

Res. 48 — Public Act 350, 1913 as Amended Regulating County Public Hospitals. This resolution directed that MSMS cooperate with the Michigan Hospital Association in preparing, introducing and urging an amendment to correct certain discriminations against physicians and women as members on county hospital boards of trustees. House Bill 4079, a bill to enact the directive and which was sponsored by MSMS, was introduced in the 1970 legislative session, but failed to be reported out of committee.

Res. 49 — Blue Shield Fee Recovery Procedures. This resolution asked Blue Shield to change its policy of "dunning" physicians in cases involving coordination of benefits and to direct future action for recovery of such fees to the subscriber. This request has been implemented by Blue Shield.

Res. 50 — Physical Status Card. This resolution requested that MSMS investigate the possibility of issuing a card to interested individuals after a comprehensive physical examination. The card could be presented in lieu of individual examinations for various activities which are presently required.

The Council referred this resolution to the Committee on Public Health for study and recommendation. The Committee felt there was merit in such a card, but recognized the possibility that insurance companies, individual physicians and others might not accept such a card, and that it might conflict with present laws and public health regulations. The matter was referred to a subcommittee for further investigation.

Res. 51 — Medical Defense. This resolution requested the Committee on Professional Liability Insurance to study the feasibility of creating MSMS machinery for alleged malpractice. The matter has been referred to the Professional Insurance Plans Committee which has it under study.

Res. 52 — Obesity Research and Education. The House took no action on this resolution.

Res. 53 — Establishing an MSMS Negotiation Counseling Service. (Substitute adopted, see Resolution 5 above.)

Res. 54 — Economic Relief for Working Women. This resolution was referred to the Committee on Medical Socio-Economics, which currently has it under evaluation.

Res. 55 — Seminars in Law and Medicine. This resolution expressed commendation to Wayne State University for its new seminar course in Law and Medicine and directed that the program be brought to the attention of the other medical schools and the AMA Judicial Council. This was done by letter to the Deans of the medical schools and to the secretary of the Judicial Council.

Res. 56 — Athletic Medicine. This resolution urged the State Board of Education and Department of Public Health to require every school to have an "athletic medicine unit" and asked all medical schools in Michigan to train athletic health coordinators. The amended resolution directed that copies of the resolution be sent to the Governor, Legislature of Michigan and other specified authorities. Responses from parties to which the resolution was sent indicate substantial interest on the part of administrative and educational and legislative personnel alike.

Res. 57 — Hospital Privileges for Physicians. This resolution was disapproved by the House.

Res. 58 — Malpractice Hazards and Costs. This resolution was disapproved by the House.

Res. 59 — Reproduction by MSMS of Copyrighted Material Produced by the John Birch Society. This resolution was disapproved by the House.

Res. 60 — Authority of the Food and Drug Administration. This resolution was not approved, but the House directed that an appropriate committee prepare a position paper on "the undue influence of the FDA in the practice of medicine," for the use of the Michigan delegation to the AMA in preparing a resolution for introduction in the AMA House of Delegates. The introducer of the resolution was requested to prepare such a position paper and it was presented to the Michigan delegation for its information.

Res. 61 — Active MSMS Membership for Doctors of Osteopathy. This resolution added doctors of osteopathy to the Bylaws section setting forth those who may be active members of MSMS. This change was implemented in the September 1969 revision of the Constitution and Bylaws.

Res. 62 — Control of Juvenile Delinquency. This resolution stated as a matter of principle that the State Legislature should provide more funds for institutions to rehabilitate juvenile delinquents. A letter of transmittal was sent to the appropriate legislative and executive personnel.

Res. 63 — Reintroduce Malpractice Bills. This resolution directed The Council to support certain bills on malpractice and urge their adoption. The resolution was referred to the Legal Affairs Committee for implementation. However, in spite of MSMS support, these bills died in committee.

Res. 64 — Support of Blue Shield Program. (Substitute adopted, see Resolution 44 above.)

Res. 65 — Drug Abuse. This resolution determined to support any legislation calling for funds to treat abusers of drugs, directing that the resolution be given wide distribution. Copies of the resolution were transmitted as directed and responses indicate support for the position taken.

Res. 66 — Liaison with Michigan Blue Shield Representatives. This resolution asked that the Michigan Medical Service Board specifically invite MSMS representatives to each Blue Shield board meeting, sending a schedule of all meetings and related materials to MSMS sufficiently in advance for adequate study. The Blue Shield Board has complied with these requests.

Res. 67 — Third Party Interference in Physicians' Fees. (Substitute adopted, see Resolution 2 above.)

Res. 68 — Crime and Delinquency. This resolution directed that MSMS join with other state medical societies in aiding the American Medical Association in education programs dealing with the medical aspects of crime and delinquency. MSMS willingness to participate in such programs was transmitted to the AMA.

Res. 69 — Modernization of the Present Medical Practice Act. This resolution was referred to the Legal Affairs Committee without recommendation.

Res. 70 — Government Participation in Medical Care. This resolution stated that government participation in medical care should be limited to a contribution to financing according to the individual recipient's needs as determined by his economic circumstances. This position was forwarded to the AMA Legislative Department for their consideration in dealing with relevant legislative matters.

Res. 71 — Increase in Professional Liability Premiums. This resolution directed that The Council request the Michigan Insurance Commissioner to hold hearings on any such rate increases, and that an MSMS representative be present at such hearings.

The Council requested MSMS Legal Counsel to comment regarding the desirability of the proposal. Legal Counsel suggested that the purposes of the resolution might be taken up with the Commissioner's office by someone on the staff. He pointed out, however, that no actuarial data was available to be of assistance at such hearings and that no member of the staff had sufficient expertise in this area to make a meaningful appearance. The Council Chairman was authorized to assign a staff member to contact the Commissioner's office regarding this matter.

Res. 72 — Acceptance of Assignments by Blue Shield. This resolution was disapproved by the House.

Res. 73 — Socio-Economic Policy, Information and Assistance. (Substitute adopted, see Resolution 5 above.)

Res. 74 — Medicare Freezing of Rate of Payment. This resolution directed MSMS Legal Counsel to make a test case in the courts on freezing of fee schedules. The Council referred the matter to Legal Counsel for his opinion regarding the proposed challenge of the HEW ruling. Legal Counsel's opinion indicated that extended research would be required before any meaningful decision could be made with respect to the commencement of a case of such magnitude. Legal Counsel believed that before one got into this The Council should re-examine the resolution from a non-legal standpoint. This matter has been referred to the Finance Committee for study and report.

Res. 75 — Blue Shield Letter. This resolution was disapproved by the House.

Res. 76 — Michigan Medicine to Operate Within Budget. This resolution was disapproved by the House.

Res. 77 — Medicaid Payments for Routine Care. This resolution urged Medicaid payments to physicians for providing medical services such as routine physicals, Pap smears and pre-school exams to indigents. The House referred the resolution to the Committee on Governmental Medical Care Programs for its consideration.

Res. 78 — Veterans Administration Payments to Physicians. This resolution directed the Committee on Governmental Medical Care Programs to make every effort to obtain improved payment for physicians' services on the usual, customary and reasonable fee concept. The Committee met with Veterans Administration executives and was told that V.A. makes every effort to establish a schedule consistent with those generally prevailing.

The Committee was also informed of the reasons why V.A. does not use the payment formula authorized in the Medicare-Medicaid-CHAMPUS programs. V.A. spokesmen told the Committee that the V.A. schedule is re-evaluated if there is justification for increasing procedural values; that office visit fees had been raised; and suggested that physicians should continue to submit their charges on a reasonable basis.

Res. 79 — Contribution to the Michigan Health Council. This resolution was disapproved by the House.

Res. 80 — Right of Vote in MSMS House of Delegates by Specialty Section Delegates. The House instructed the Speaker to appoint an ad hoc committee to study the modus operandi for establishing a working relationship of specialty societies in the House. This committee was directed to report to the 1970 House and the resolution itself was laid over until 1970, in accordance with the Bylaws. (See Report of the Committee on Relationship of Specialty Societies in the House which is being submitted directly to the House.)

Res. 81 — On the Question of MSMS Discontinuing Support of Blue Shield. (Substitute adopted, see Resolution 44 above.)

Res. 82 — Michigan Medical Service Drug Program. This resolution asked Michigan Medical Service to supply all pertinent details of the MMS Drug Program to all members of MSMS. This substitute resolution also covered Resolution 83 which directed a study of the propriety of MMS involvement in the Prescription Drug Program. Blue Shield reported that it had complied fully with the request.

Res. 83 — Propriety of MMS Involvement in Payment of Prescriptions. (Substitute adopted, see Resolution 82 above.)

Res. 84 — Selection of MSMS Nominees to MMS Board. This resolution requested modification in the present method of selection of MSMS physician candidates to the Blue Shield Board. It directed each Councilor of MSMS (and each County Medical Society, if they wish) to submit names of candidates for the Blue Shield Board to a nominating committee appointed by the Speaker and MMS. The committee is to make names of candidates and their qualifications available earlier than has previously been done. The revised method of selection has been implemented for 1970.

Res. 85 — Term of Office for Michigan Medical Service Board Members. This substitute resolution urged removal of the two three-year term limitation for board members, and directed that MSMS employ adequate staff to serve the physician members of the board. The House also referred to The Council a proposal that MSMS reimburse physician members of the Board for their attendance at board meetings.

In response to the resolution, the Blue Shield Board voted to abolish the term limitation for board members, so this is no longer in effect. The proposal to furnish staff to serve the physician board members was referred by The Council to the Advisory Committee to the Director, which is considering this matter, along with other matters contained in the Alexander Grant Company management study.

Reimbursement of board members was referred to the MSMS Committee on Utilization and Health Insurance Problems for consideration. Subsequently The Council adopted that Committee's recommendation that The Council recommend to the House of Delegates that physician members of the Board *not* be reimbursed. (See Part II of the Annual Report of The Council for further details.)

Res. 86 — Michigan Medical Service Articles of Incorporation. This resolution directed that a pamphlet containing Blue Shield historical information such as the enabling act, bylaws, consent judgment, etc., be developed and distributed to the House of Delegates. This reference information is being sent to the Delegates in advance of the 1970 meeting.

Res. 87 — Termination of Chiropractic Services by Michigan Blue Shield. This resolution was disapproved by the House.

Res. 88 — National Health Insurance Program. This resolution directed The Council to take appropriate action to prepare in advance for any system of national health care. This matter is being studied by the MSMS Committee on Planning and Priorities which is considering general Society goals for the future.

6. President's Address — Robert J. Mason, MD

Traditionally it has been deemed appropriate for a retiring president in making an exaugural address to dwell on glowing terms of the magnificent accomplishments during the previous administrative year.

Each year, the address is delivered in flowing terms describing how the incoming president had charged into the multitude of tasks and accomplished untold good works.

I find myself in a rather unusual position at this time . . . because I cannot speak in these traditional terms.

I feel a certain amount of frustration in having not accomplished what I had hoped to achieve.

And so I come to you today with an expose of things that were not accomplished, but still with a burning desire that these goals and ideals will be achieved. Last year I described certain social-medical ideals that I felt important. A year ago I spoke of my desire to change certain concepts in our thinking in regard to three specific social problems, namely:

Our additude on abortions. Secondly, a desire for sterilization of medically unfit individuals, and thirdly, an expansion of our concept of the right of all individuals to have the opportunity to die with dignity. These social-medical needs have not been adopted and I feel that there is still an opportunity for continued constructive thinking in these three areas.

This has been a very fascinating year for me. It provided the opportunity to travel to various neighboring states around the Great Lakes area, and to review with other state medical societies their concepts of where medicine is going today and to tell them of our accomplishments in Michigan. I visited the annual sessions and the state medical societies in Pennsylvania, Ohio, Indiana, Illinois, Wisconsin, and Minnesota. The friendships formed in these areas will be long-lasting.

I feel that this exchange of ideas with sister states is desirable and should be continued.

This past year I also had the opportunity to visit with the medical leaders in twelve Michigan counties and to explain to them the functioning of the headquarters of MSMS. I told these component medical society leaders how the State Medical Society is attempting to build a strong bulwark for the general well-being of *all* the doctors of Michigan. I find the medical leaders in all areas of the State deeply concerned with the advancement of medicine. These medical leaders, across the state, are sincerely trying to take care of the medical needs of the citizens of Michigan.

You will hear, in the reports of other MSMS officers, about the many changes that are taking place internally in the structuring of the MSMS Council and officers group. You will hear how we have turned a very critical eye upon ourselves and how we are diligently trying to revamp our internal organization for an even more efficient conduct of our MSMS headquarters activities. I feel that these studied efforts will contribute a great deal to the establishment of a smooth-running organization. The fruits of these changes will be apparent to all of you as time progresses.

Let me with pride tell you about the devotion of the headquarters staff to the total functioning of this State Society. With real gratitute and appreciation I can testify to the effectiveness, the efficiency and the whole-hearted cooperation exemplified by our headquarters staff. I can assure you that our staff—in comparison with other state medical societies—carries a much greater workload and accomplishes our goals with much less personnel than is being done in other state organizations. I salute our headquarters staff and commend them to you for your future cooperation and appreciation of the fine work that they are doing.

I take pride in thanking The Council and the elected officers of this Society for the splendid cooperation they have extended to me during the past year. Without this support, understanding, and cooperation, my year as President would have been much more difficult.

I personally thank each of them!

I am sure that the cooperation of the elected officers and Council will be extended to the new in-coming President.

The workload will continue to be heavy. The challenges are great. The opportunities for continuing service will require much thought and deliberation. I am certain the new administrative officers can depend upon the support of all.

In reflective retrospect, I would like to make several specific recommendations which I feel are worthy of future consideration. These proposed projects can be implemented for the good of the State Society.

I would like to suggest the formation of an Advisory Committee of Past Officers. These men possess a great backlog of information and knowledge about the medical problems confronted by the Society. Such an Advisory Committee could make valuable recommendations from time to time to The Council for the on-going well-being of medicine.

Next, I would like to recommend the formation of an Advisory Committee consisting of a consumers group, or local opinion makers who could advise the Medical Society on the impact of medical programming on the total community. The AMA has such a new Advisory Council and early reports are encouraging.

Again, I would like to suggest from a communications' standpoint the sponsorship of a statewide "Teen Week" or "Youth Week in Health" program. Outstanding high school juniors and seniors could be brought together for a conference, programmed and geared to the adolescent and youth concerns they are encountering. Such a program has been most successfully carried out in Indiana and Wisconsin and great credit could be accrued by our Medical Society in the conduct of such a program. Virtually every youth issue today —drugs, smoking, family-life eduation, etc., are health related and the medical profession can offer answers and advice.

In conclusion, I would like to most humbly thank the physicians of Michigan for having elected me as the 104th MSMS President . . . and for giving me this opportunity during the past year to have served you and the great Michigan State Medical Society.

THE REFERENCE COMMITTEE on Reports of The Council and Officers, E. E. Elder, MD, Chairman recommended approval of the President's Recommendations concerning utilization of the Committee of Past Officers, the formation, if feasible, of an Advisory Committee of Consumers and the support of "Youth Week in Health."

THE HOUSE adopted the report of the Reference Committee.

7. President-Elect's Address — Harold H. Hiscock, MD

The purpose of Michigan State Medical Society, as stated in our Constitution, focuses on the scientific side of medicine. We have done an excellent job, especially in the past 40 years, to improve medical care.

MSMS, through our annual meetings and postgraduate programs, along with the excellent programs put on by our specialty groups and the many programs given almost daily by our hospital staffs, provides ample opportunity for our members to keep abreast of the rapid changes in medical care.

We will continue these programs as we fulfill our major reason for being.

The time has come for MSMS to move into the economic field, if MSMS is to continue as the major force in medicine in this state.

Our members are demanding this, which is evident by the fact that a majority of specialty groups have had to do this for themselves: such groups as pathology, radiology, internal medicine, urology, general practice, and newly-formed emergency room groups. At this session the anesthesiologists have introduced a resolution on this subject.

It is evident to me that we can increase the value of the State Society to its members if we:

(1) Provide them with a current relative-value fee schedule.

(2) Provide them with information as to the cost of providing health care in various communities, and

(3) Provide information as to how they can improve delivery of health care to their community.

Our first attempt on the part of MSMS to develop a fee schedule was done several years ago when we produced our first fee schedule for government agencies. This schedule was accepted by many county welfare departments. Two or three years later we developed another fee schedule which greatly upgraded our fee schedule to the many specialty groups, especially internal medicine. This, too, was accepted by many welfare departments, and was being used at the time of the advent of Medicaid. An interesting fact was that this fee schedule was not associated with the fee schedule of any insurance company. The negotiations with the county board of supervisors was done by a committee of the county medical society and *not* by an outside agency.

I know there has been some criticism of a fee schedule, but this does not seem to be valid, inasmuch as our specialty groups have had to develop fee schedules on their own. Our members have the right to look to their State Society for this service. I know most urologists in the state use the fee schedule produced by the American Urological Society. Different areas of the state use their own conversion factor.

In the late 1930's, before the advent of the Tissue Committee, doctors used to say, "No-one is going to tell me how to practice medicine." But they did with the improvement in medical care. Now doctors are saying, "No-one is going to tell me how much I am going to charge my patients for my services." Maybe in the near future an economic committee of doctors will change that to the betterment of our patients' and members' economic status.

Our present MSMS relative-value fee schedule should be updated as soon as possible. The various county medical societies should adopt annually their own conversion factor that will reflect the increase in living cost, as well as increased costs of office overhead.

Relative-value fee schedules should reflect the usual customary fee of each of our counties. There should be no fixed state-wide fees that might be adequate in one area and substandard in some areas.

I attended the meeting of State Presidents at the AMA meeting in Chicago last June. I met with Presidents from California, Washington, Connecticut, Indiana, Georgia, and the District of Columbia. The question was raised, "What is the actual cost of running our private offices?" We were all surprised that none of our organizations had little or any information on this subject. Yet, if we are to answer our critics as to rising costs of medical care, this information should be available. There has been criticism of the differential fee schedule in different sections of our state. This may or may not be valid, but we must have actual knowledge of the cost of delivering health care in different communities so we may prove or disprove this. The time has come when no county in our state can be isolated economically from the doctors of the rest of the state. There has to be some unity in action.

One cost that all surgeons are very aware of is the increased cost of liability insurance. We also know that this increase has driven away many doctors who were capable of doing minor surgery from providing this service to their patients, because the cost of insurance was prohibitive.

Historically, the practice of medicine has been carried on by independent "shopkeepers." Some are very capable businessmen, while others have paid little attention to the actual cost of running their offices. It is time to pool our knowledges and our resources so that we can reduce this ever-growing overhead.

There has been a great deal of criticism of our present method of practicing medicine in our private offices. I've read many of these in the past ten years, the last of which was in the April issue of *Scientific American.* This was written by an official of Kaiser Permanente plan. He believes that this present plan and our plans are both wrong. He proposed a complicated system that I doubt even he understands. In none of these criticisms has there been any statement as to how this will improve the medical care of our patients, nor whether it will provide care for this uncertain number of patients who, we are told, are unable to obtain medical service, nor whether it will decrease cost of health care.

I believe we must have faith in the history of our profession and attempt to improve our present system, but we should not listen to these critics and become emotionally upset and make changes just for the sake of making changes.

We must strengthen our State Medical Society and our county medical societies so that they can control the delivery of health care in our counties and in our state. There are many organizations that are attempting to divert this from our organizations.

I've heard and read about the new Association of Hospital Staffs in New Orleans. It appears that they, by a united effort, were able to change certain medical practices in their community. We don't need a new organization. What they did could have been accomplished by their county medical society. Maybe it is time that our chiefs of staff of our various hospitals or representatives of the medical executive staff should become voting members of the Board of Directors of our various county medical societies. By such a move we would be better able to counteract the moves of hospital administrators and their lay Board of Directors so that we could avoid any regulation on their part that would make physicians unable to exercise their best medical knowledge in patient care.

Another group that is trying to control a part of the practice of medicine in our areas is the area-wide advisory councils for comprehensive health planning. We must insist through united action that we place on their executive boards an adequate number of doctors of *our* choosing.

If MSMS is going to assume the awesome responsibility of the things that I have meagerly outlined, then you must also assume the more awesome responsibility of adequate peer reviews and utilization review committees. Only MD's can assume the responsibility of these committees. These committees must be under the control of our county and state medical societies and be responsible only to them.

It would take a very long report to cover all the problems that will be facing MSMS in the next few years. I'm sure all of our answers will not be the right ones but then we are all accustomed to that in our scientific medicine for what is adequate treatment today often becomes inadequate tomorrow. However, if we don't become too emotionally involved and try to change everything all at once and if we don't have fears of what might happen, our great scientific medicine will be saved and the future economic status of our members will be secure.

In conclusion, I would like to quote from former Secretary of Health, Education, and Welfare Wilbur J. Cohen. In 1969, upon leaving office, he wrote the nation's physicians:

"The highest quality of medical service for all American people is dependent on freedom on the part of each individual physician to care for his patients in accordance with his best medical knowledge."

THE REFERENCE COMMITTEE on Reports of Council and Officers, E. E. Elder, MD, Chairman recommended approval of the President-Elect's recommendations concerning the updating of the RVS and the compilation of figures regarding the overhead cost of medical practice.

THE HOUSE approved the report of the Reference Committee.

8. Treasurer's Report — John R. Ylvisaker, MD

I. The Asset Management Program.

Two reserve funds were established in 1968 as authorized by the House of Delegates.

The Capital Reserve Fund was designed to provide basic dollar reserves to meet unexpected expenses, inadequate income, and extra-budgetary capital expenditures. An investment policy emphasizing stability, income, and conservative growth potential was outlined and has been followed. Despite the fairly marked decline in the market as illustrated by the Dow-Jones average, the Capital Reserve Fund has approximately maintained its original dollar value:

Original Investment		$252,000
Present Status		
Fixed dollar	$ 85,000	
Stocks	130,000	
Real Estate (Cost)	34,000	
	$249,000	249,000
Market value depreciation		$ 3,000
Present yield		5.6%

The Capital Protection—Creative Reserve Fund was designed as a more aggressive, growth-oriented fund to provide basic dollar reserves for future creative or innovative programs in development and research or in member benefits.

Because securities having growth characteristics are more sensitive to economic condition, this fund has experienced an erosion of market value in proportion to the decline in the market. It is essential to recognize that this fund retains a strong recovery potential which is well protected by the total lack of need for liquidation.

Original Investment		$375,000
Present Status		
Fixed dollar	$ 64,000	
Bonds	30,000	
Stock	179,500	
	$273,500	
Market value depreciation		$101,500
Present yield (related to original invested dollars)		5.2%

Although the Capital Reserve Fund obtains a few new dollars annually through the funding of depreciation, both funds are hampered by the relative lack of available new dollars to take advantage of the dollar-averaging opportunities of a depressed market. No mechanic is available at present to overcome this disadvantage.

II. The Financial Condition of MSMS

MSMS is operating within its budget and is in sound financial condition. The 1970 budget reflects a projected 5% increase in expenditures and a substantial increase in income as a consequence of the $25 per member increase in dues. The increased income will correct a $25,400 deficit in the 1969 budget and provide a projected 1970 surplus of $83,540.

Throughout the year surplus dollars are maintained in short term, high grade, fixed dollar securities providing interest returns of 7¾ to 8½%. These funds are programmed to allow a maximum term for interest-bearing before progressive release to satisfy budget expenditures.

The first phase of the Management Study authorized by the House of Delegates by the approval of the 1969 Treasurer's Report was completed and The Council has approved for implementation recommendations for a constructive revision of the Headquarters administrative organization. The revision should accomplish an increase in efficiency, productivity, accountability, and a better distribution of responsibility. The effect of the budget for 1971 will depend on the progression and mode of implementation but should be negligible. A 5% increase in the cost of doing business and a 1% increase in income is projected for next year as previously. Without new commitments the progression of cash flow may be represented as follows:

	1969	1970	1971
Income	$778,300	$955,000	$965,000
Expenses	803 700	846,000	888,000
Surplus	(25,400)	109,000	73,000
(deficit)		(25,400)	83,600
Cumulative surplus		83,600	156,600

III. General Remarks and Recommendation

There has been an increasing willingness on the part of the Society to engage in constructive analysis, to challenge traditional concepts, and to effect change. This is essential to the furtherance of our purpose and to our viability. We have accomplished a great deal with recent changes but we have much to do.

MSMS, in 1970, when viewed objectively and dispassionately, has two major deficiencies:

1) A low level of participation, and therefore representation of, enrolled members.

2) An absence of tangible direct member benefits.

The dedication and capable leadership of a small percentage of the total membership cannot adequately compensate for the disinterested or perfunctory allegiance of the uninvolved. The modern-day practice of medicine, the patterns of physician group activity, as well as the established opportunities for member services are all impelling reasons for a constructive review of our present system of organization and operation. The scene of action locally has changed from artificial county boundaries to hospital staff and regional arenas based on function and mutual need.

Gentlemen, we have an unusual opportunity and an urgent need to address ourselves to these problems. We now have adequate available funds. We have a re-structured, and responsive administrative organization. And we have an uninvolved, inadequate represented membership with a lack of tangible member benefits.

I recommend authorization by The House of Delegates for a continuation and completion of the previously approved, strongly directed, professional management study for the re-evaluation and reorganization of the Society as outlined in the 1969 Treasurer's Report.

I also recommend that a Task Force to direct and supervise this study be appointed by the Chairman of The Council.

I further recommend that the House of Delegates approve the development of dues-related member benefit programs and direct The Council to develop and propose to the 1971 House a Member Assistance Fund for needy physicians and their families, as an initial step in the accomplishment of this goal.

THE REFERENCE COMMITTEE on Reports of Council and Officers, E. E. Elder, MD, Chairman recommended approval of the Treasurer's recommendations for the completion of the professional management study for the re-evaluation and reorganization of the Society and the development of dues-related member benefit programs.

THE HOUSE adopted the report of the Reference Committee.

9. Report of the Michigan Delegation to the American Medical Association — Donald N. Sweeny, Jr., MD, Chairman

(The following report of the Chairman was presented in written form.)

Summary of Actions of the AMA House of Delegates,
119th Annual Convention–Chicago, Illinois,
June 21-25, 1970

In its first uninterrupted Annual Convention since 1967 (thanks to the most elaborate security precautions ever taken), the House of Delegates considered a record volume of business; passed a hotly debated statement on abortion; and raised membership dues to help finance need programs.

Elections

Wesley W. Hall, Nevada, was elected President Elect. He will become the 126th President of the AMA in June, 1971.

H. Thomas McGuire, Delaware, was elected Vice President and Russell B. Roth, Pennsylvania, and J. Frank Walker, Georgia, were unanimously re-elected to their posts as Speaker and Vice Speaker of the House, respectively.

John H. Budd, Ohio; Richard E. Palmer, Virginia; James H. Sammons, Texas; and Kenneth C. Sawyer, Colorado, were elected to fill the four vacancies on the Board of Trustees.

George W. Petznick, Ohio, was re-elected to the Judicial Council.

M. Louise C. Gloeckner, Pennsylvania, was elected to the Council on Constitution and Bylaws.

Warren L. Bostick, California, and Bernard J. Pisani, New York, were elected; and Bland W. Cannon, Tennessee, was re-elected to the Council on Medical Education.

Paul W. Burleson, Alabama, was elected; and Donald R. Hayes, Massachusetts, and W. B. Hildebrand, Wisconsin, were re-elected to the Council on Medical Service.

Otto Engelke, MD, Ann Arbor, Michigan and John Moses, MD, Detroit, Michigan were defeated in bids for Vice President and Council of Medical Education.

House Actions

From June 21 through June 25, the House was in business sessions for 17 hours and 15 minutes, during which it considered a record 201 items of business. Included were 61 reports—31 from the Board; 3 from the Judicial Council; 6 from the Council on Constitution and Bylaws; 10 from the Council on Medical Education; 5 from the Council on Medical Service; and 6 special reports. It also dealt with 140 resolutions—8 un-numbered memorial or commendatory ones; 27 special ones generated by the (Himler) Committee on Planning and Development; and 105 from regular sources.

1. *Abortion*

After long debate before the reference committee and on the floor of the House, delegates adopted the following statement on abortion:

"Whereas, Abortion, like any other medical procedure, should not be performed when contrary to the best interests of the patient since good medical practice requires due consideration for the patient's welfare and not mere acquiescence to the patient's demands; and

"Whereas, The standards of sound clinical judgment, which, together with informed patient consent should be determinative according to the merits of each individual case; therefore be it

"Resolved, That abortion is a medical procedure and should be performed only by a duly licensed physician and surgeon in an accredited hospital acting only in conformance with standards of good medical practice, and after consultation with two other physicians chosen because of their professional competence, and within the Medical Practice Act of his State; and be it further

"Resolved, That no physician or other professional personnel shall be compelled to perform any act which violates his good medical judgment. Neither physician, hospital, nor hospital personnel shall be required to perform any act violative of personally held moral principles. In these circumstances, good medical practice requires only that the physician or other professional personnel withdraw from the case so long as the withdrawal is consistent with good medical practice."

2. *Consumer Forum*

For the first time in its history, the House appointed a special reference committee to hold a public forum, at which individuals and representatives of groups could present their views of medical and health care. The committee heard three hours of testimony on the opening day of the convention. From its report, the House adopted the following recommendations:

"That consideration be given by the Board of Trustees to the creation of a multi-ethnic advisory committee on health care problems of minority groups.

"That the House of Delegates reaffirm its policy of encouraging physicians, as well as paramedical personnel, to continue to provide compassionate and sympathetic care to all patients.

"That the House of Delegates reaffirm Resolution 62, Annual Convention 1969, which states in part: 'It is a basic right of every citizen to have available to him adequate health care' . . . and that 'the medical profession, using all means at its disposal, should endeavor to make good medical care available to each person.'

"That the AMA Advisory Committee on Health Care of the American People be invited to participate in reference committee hearings" of this type if they are held in the future. Consideration of having such an open forum at each AMA convention was referred to the Board of Trustees.

3. *Dues Increase*

Until this convention, the amount of AMA dues was prescribed by the Board, for adoption or rejection by the House. On Tuesday, however, the House amended the bylaws to give itself that responsibility. Chapter III, Section 1 (A) of the bylaws now reads:

"(A) How Prescribed—Annual dues for any year shall be prescribed in an amount fixed and determined by the House of Delegates.

The Board of Trustees may submit recommendations to the House on the fiscal needs of the Association and the level of dues. Dues fixed by the House shall remain in effect until changed."

In response to Board Reports A and B (financial statement of the AMA, and background detail on the need for an increase), the House voted to increase annual AMA dues by $40, to $110. At the same time, the House directed that "basic and explicit information supporting the need for this dues increase, and future dues increases, be promptly disseminated by the AMA to individual members by every reasonable and available means possible; and that the aid of constituent state associations be enlisted in this effort."

The new dues will become effective with the next fiscal year, beginning December 1, 1970.

4. *Planning and Development*

One of the longest debates of the meeting involved creating a body for long-range planning and development. When the matter was settled, a standing committee of the House—the Council on Long-Range Planning and Development—had been created and the bylaws had been changed appropriately to accommodate it.

The council will have nine members. Four will be appointed by the Speaker (two from the House and two from AMA membership at large) and four will be appointed by the Board (two members of the Board and two from AMA membership at large). The ninth member will be appointed by the President of SAMA. The council is required to submit reports to the House at each regularly scheduled convention of the AMA.

The House also acted on the recommendations of the earlier Committee on Planning and Development (Himler committee). Here are those recommendations as adopted by the House, sometimes after extensive revision:

Recommendations

That the AMA reaffirm, as a statement of the primary purpose and responsibility of the Association and the medical profession, "the promotion of the art and science of medicine and the betterment of public health," and, as part of this purpose, apply all possible effort to make medical services of high quality available to all individuals.

That the Association has the duty to guide and assist the medical profession in the attainment of this objective.

That the American Medical Association recognize the need for multiple methods of delivering medical services, and that it encourage and participate in efforts to develop them.

That, in the interest of attracting the most highly qualified candidates to the field of medicine, it simultaneously make every effort to maintain and create incentives in medical practice. Among these incentives are a multiplicity of practice options, maximum professional independence and freedom of choice for both physicians and patients.

Health is a state of physical and mental well-being.

That the AMA expand its active role in planning and developing programs for medical care in all of its ramifications and that it encourage and assist state and county medical societies to do the same at their respective levels.

That, clearly recognizing the health of individuals has many aspects other than medical care, such as education, housing, environmental control, transportation, civil rights, and the alleviation of poverty, the American Medical Association continue to show an active, innovative and constructive interest in these non-medical components of health services.

That the AMA and the constituent and component medical societies seek the active cooperation of all physicians, both as individuals and as members of medical staffs, in medical service projects for areas in need of medical services.

That the AMA, through its Council on Health Manpower, in conjunction with county and state medical societies and other professional, education, and lay associations, continue to explore and develop expedients to overcome health manpower shortages.

That the Association, in its future declarations and activities directed toward the alleviation of shortages in health services and personnel, underscore the fact that these shortages are not due merely to an insufficient number of health professionals across-the-board, and emphasize that maldistribution of practitioners geographically, by profession, and by specialty is an equally important factor in depriving communities of an adequate supply and spectrum of health services.

That the Association publicize the reasons for the maldistribution, as outlined in this section, and stress that the voluntary correction of these deficiencies requires public cooperation and community action in addition to the measures taken by the health professions.

That an appropriate Committee of the AMA immediately begin to formulate a policy on physicians' assistants, particularly with regard to their responsibilities, limitations on their services, and supervision of their services by qualified physicians.

That the AMA reaffirm the principle that the basic responsibility for the medical care of patients lies with their physicians of record and that that responsibility cannot be legally or morally delegated.

That the AMA approve in principle certification of educational programs for physicians' assistants but oppose licensing of these individuals by any state agency.

That the Association's Law Division upon request assist the state medical societies in identifying and avoiding any legal hazards that may accompany the employment of physicians' assistants.

In seeking as its goal the highest quality and availability of patient care, the American Medical Association advocates factual investigation and objective experimentation in new methods of delivery of health care, while still maintaining faith and trust in the private practice of medicine and pride in its accomplishments.

That the Association, in appropriate public statements, emphasize the concept that differences in education, state laws, culture and income levels create problems that may necessitate different systems of delivering medical care for different population groups and different geographic areas.

Urge state medical associations to establish bureaus or departments of economic research, development and planning to study, develop and disseminate data concerning the economic aspects of medical practice.

Through the AMA's Departments of Survey Research and Economic Research, continue to assist state associations in collecting such data and to act as a clearinghouse for data so gathered.

Encourage state medical associations to designate representatives to deal energetically with third party agencies and programs, utilizing the concept of usual, customary or reasonable charges.

That the AMA reiterate its support of sound, existing mechanisms, such as public grievance and adjudication committees, and utilization and peer review committees, which state and county medical societies have found to be most appropriate and effective for the consideration of fees and the costs of medical and related care.

Endorse the principle of voluntary, life-long postgraduate study for all physicians and continue and accelerate the development of programs and incentives for such study.

That the AMA encourage and assist all state medical associations to devise programs for voluntary postgraduate study designed to maintain medical education at the optimum level with the primary objective of assisting the physician in rendering professional services to his patients. These programs of postgraduate study should be mindful of the many demands on the time of the busy physician, and his responsibilities to his patients and his practice, and should be least disruptive to the provision of medical services.

That the Association obtain information from each state medical society as to whether special requirements have been imposed on physicians who render services to patients under the provisions of tax-supported programs and obtain the specifics of what those requirements are.

That in those states where the health or welfare departments have imposed special requirements on physicians to participate in their programs, the medical society reject those requirements and that, if the need for such regulation can be demonstrated, the state medical society, education department, and health department cooperatively develop standards to be incorporated into the education law and enforced on all physicians of that state, thereby eliminating double standards for medical practice and restoring the licensing authority to the proper agency.

The AMA, on the basis of the data received from the state medical societies, (1) continue to identify the services that comprise good medical care; (2) develop guidelines that state and county medical societies may use in evaluating needs and priorities of medical services in their respective areas, and (3) ensure that these data and guidelines are widely distributed and publicized.

That the present structure of the Association be retained and that it be strengthened by improvements and modifications in its function.

That on implementation of the program for organization and reorganization, a planning council with appropriate subcommittees be formed for the purpose of processing data and formulating policy recommendations for the consideration of the Board of Trustees and the House of Delegates.

5. *Education*

In December, 1968, the House agreed that "an ultimate goal is unification of the internship and residency years into a coordinated whole." To move closer to that goal, in this meeting the House adopted the following statements:

"After July 1, 1971, a new internship program shall be approved only when the application contains convincing evidence that the internship and the related residency years will be organized and conducted as a unified and coordinated whole.

"After July 1, 1975, no internship program will be approved which is not integrated with residency training to form a unified program of graduate medical education."

The House also adopted or approved essentials of approved programs in continuing medical education; essentials of an accredited educational program for histologic technicians; revision of essentials of approved internships and residencies pertaining to part-time appointments; essentials for approval of examining boards in medical specialties; revision of essentials of approved residencies in child psychiatry; revision of essentials of approved internships and residencies to add statement on employment relationships of house officers; revision of essentials of approved residencies in neurological surgery; revision of essentials of approved residencies in pathology; and revision of essentials of approved residencies in internal medicine.

A permanent Section on Neurological Surgery was created in the Scientific Assembly of the AMA.

6. *Professional Liability*

The House approved a Board report stating that liability insurance protection is essential so that physicians may continue to provide needed medical care to the public. "It has been concluded," the report said, "that the best way to provide such assurance is on a collective, rather than an individual basis, under programs jointly sponsored by the American Medical Association and the respective state medical association. . . Minimum standards for an effective sponsored insurance program are being developed" and the Professional Liability Committee of the Board "is seeking with the insurance industry a means for instituting qualified insurance programs under such joint sponsorship with state associations which elect to participate."

7. Nurses and Other Allies

The following AMA position statement on nursing was adopted:

"The American Medical Association recognizes the need for, and will support efforts to increase, the number of nurses; recognizes the need for, and will facilitate the expansion of, the role of the nurse in providing patient care; encourages and supports all levels of nurse education; will promote and influence the development of a hospital nursing service, similar to a medical care service, under the leadership of a chief of professional service, aimed at increased involvement in direct medical care of the patient; supports the concept of the physician-led health team; and will seek constructive collaboration with the total nursing community."

The House also resolved that "the American Medical Association undertake a thorough investigation of a method to bring allied professions into a collaborative relationship with the AMA such as the establishment of a new class of membership;" and "that consideration be given to preparing 'essentials' for those categories of the allied health personnel groups which do not have them, and that the opportunity for vertical and horizontal mobility be considered in determining these 'essentials.' "

8. Convention Sites and Dates

The 122nd Annual Convention of the AMA, originally scheduled for July, 1973 in New York, has been changed to June 24-28. It will be in New York.

The Clinical Convention of 1972, originally planned for Atlanta, will be held in Cincinnati, Ohio. The 1976 Clinical will meet in Philadelphia.

This is the line-up now:

	Annual	*Clinical*
1970	Chicago	Boston
1971	Atlantic City	New Orleans
1972	San Francisco	Cincinnati
1973	New York	Anaheim
1974	Chicago	Portland, Ore.
1976		Philadelphia

9. Drugs

The House took a number of important actions in connection with drugs. Among them:

That the AMA "encourage Committees on Pharmacies and Therapeutics in each hospital to review drug reactions and related problems and to take appropriate control measures and to initiate informational programs."

That the AMA "seek passage of legislation for control of the manufacture and distribution of barbiturates and amphetamines."

That the AMA "expresses the concern of the medical profession that consumer protection be assured through more adequate surveillance of proprietary drug advertisements by private organizations and more effective cooperation in enforcement of applicable regulations by responsible governmental agencies."

That the AMA "supports dispensing by pharmacists of all medications in child-protective containers, and encourages acceptance of the containers by parents."

And that it is contrary to the public interest to repeal or modify "anti-substitution laws and regulations in order to permit the filling of prescriptions with therapeutic agents not intended by the prescribing physician." The House declared its intention "vigorously to support the maintenance and enforcement of anti-substitution laws and regulations."

10. Hospitals

The House resolved that "the terms 'negative,' 'within normal limits,' and 'normal' be approved by the JCAH as acceptable designations for use in hospital charts."

It also resolved:

That the AMA request the JCAH to specify that a Joint Conference Committee "include, where feasible, adequate representation from community-based physicians elected by the medical staff."

That the AMA reaffirm its position that "general practitioners should have the opportunity to practice medicine as active staff members in hospitals and should be granted privileges commensurate with their training and demonstrated abilities."

And that the AMA suggest that "medical staffs consider revising their respective hospital medical constitutions and bylaws to differentiate clearly between medical and administrative duties."

11. Miscellaneous

Approval was given to Report A of the Judicial Council, which said, among other things, that "It is not in itself unethical for a physicial to own a for-profit hospital or interest therein. The use the physician makes of this ownership or interest may, however, be definitely unethical. For example, for a physician to send a patient to such a hospital or to prolong a patient's stay in the hospital for his financial benefit would be unethical."

The bylaws were amended to permit osteopaths in military service to become service members of the AMA.

The House resolved to "support continuing efforts by the American Medical Association to inform the medical profession of the value and benefit to be realized from the implementation of adequate peer review programs" and directed the Board, the Council on Medical Service and "other appropriate sections of the AMA" to give this project "the highest priority and emphasize its urgency to all state and component medical societies."

Mindful of its obligation to protect public health, the House called on each state society "to take whatever steps are necessary to inform state legislators about the health hazards posed by the cult of chiropractic." It also encouraged medical schools "to include specific information in their curricula regarding the nature of the health hazard to individuals . . . posed by quackery in general and the unscientific cult of chiropractic in particular."

The House directed the AMA to make a detailed and comprehensive study and analysis of the methods and requirements for reporting infant mortality statistics "by those nations that are alleged to have a lower rate of infant mortality than that of the United States."

Delegates resolved that the AMA continue its efforts "to alert the American people . . . to the ever increasing health hazards of environmental pollution and to the urgent need for expanded research and effective control measures;" and that the AMA "further extend and intensify its present activities in pollution control and improvement of environmental health."

Considering the plight of prisoners of war in North Vietnam, the House recommended that, "in the best medical interests of both servicemen and their families, the World Medical Association and/or other appropriate international organizations be requested to use their influence with those countries which do not subscribe to the Geneva Convention to effect that (a) a list of prisoners' names be furnished, (b) inspection of prisoner compounds by neutrals be carried out, and (c) medical supplies and food parcels, as well as mail, be distributed to prisoners."

10. Report of the Woman's Auxiliary — Mrs. Edward S. Maxim

(The following report of the President was presented in written form.)

The Woman's Auxiliary has tried to follow the suggestion of the National Auxiliary to continue the Accent on Youth by trying to expand this to the strengthening of the family unit.

The major areas of concern this year have been mental health, better emergency services, AMA-ERF, and membership.

The first has been very successful, both at the county as well as the state level. Eleven county auxiliaries were instrumental in initiating community programs about Drug Abuse. Almost every county has had a program on Drug Abuse for its members. Members of nine counties were working with different State Mental Institutions. Over $2,000 was spent to purchase films, help social clubs and buy gifts for patients, equipment and books. On the State level our Mental Health Chairman, Mrs. Thomas Mudge, who is also a member of the Governor's Advisory Committee for the Department of Mental Health, prepared a workbook for the use of the county chairmen. Included in the book were how to publish a services directory, utilize a package program, set up a volunteer service, effect and appraise legislation and education (i.e., how education in schools can prevent mental breakdown later in life). Also included were the National Auxiliary basic program, Mental Health reading list, Agency directory, and a list of the County Community Mental Health Boards.

Emergency Services seem to be an area the counties are not too concerned with. Several counties are active in the Blood Bank services and some in Water Safety but most are apathetic, when it comes to becoming involved in appraising their community to see if the Emergency services are adequate.

AMA-ERF has been supported by more counties than ever before. It was my pleasure to accept at the National Convention held in Chicago, two awards of merit. The first to the Woman's Auxiliary to the Michigan State Medical Society for the largest per capita giving to AMA-ERF in the North Central Region. Our total this year was $28,265.51, an increase in giving of 25.89% over last year. The second award was to Macomb County (for the fifth year) for the largest per capita giving with a membership of between 61 - 100. Their total contribution was $4,500 with a membership of 80.

Membership has truly been a disappointment. Despite the diligent work of many individuals, on the state level, we have a decline in total membership of 149. Kalamazoo County took this as their specific project and not only had the largest member of new members but also had the consistently highest number of members at meetings. Their average attendance at meetings was twice that of the preceding year.

Several counties have had outstanding Health Career programs. Calhoun, Genesee and Ingham were the most outstanding. Over $7,876 was given out by counties as loans and $17,234 for Scholarships, making a total of over $25,000 committed to the recruitment of young people to health related careers.

Our third annual Legislation Day was our most successful to date. We were blessed with a beautiful day, weatherwise, on February 24. After a briefing in the morning by the Medical Society's lobbyist, the 61 women entertained 38 legislators for lunch. Each lady sat with her legislator so this gave ample opportunity to make the best use of the time available to discuss important issues with him. Bills we have been concerned with have been the Abortion, Single Medical Practice Act, and Basic Science Law repeal.

International Health Activities took on new meaning as individuals shared with those attending the Spring Conference, their personal experiences in International Health. One woman was a volunteer in Algiers while her husband worked in the CARE Eye Clinic, one spent nine months with a family in South Africa while her husband filled in for a Medical Missionary who was forced to return home due to illness, and a third told of the experience of establishing a small school for Indians in a remote mountainous area in Mexico.

The outstanding part of our total program was our instructional Spring Conference. With over 20 of our 41 counties having 25 or fewer members, we tried to highlight programs that individuals in the Auxiliary are carrying out, whether as a part of an organized Auxiliary or as an individual in the community. In addition to the I.H.A. program we heard from Mrs. Daniel Cline, a former President of the Midland County Auxiliary, who has written four books and produced a film about children and their fear of hosiptals. These are written so that children can gain an understanding of what happens when you enter a hospital so they no longer need fear it.

11. Report of the Michigan State Medical Assistants Society — Mrs. Patricia Austin

(The following report of the President was presented in written form.)

The Michigan State Medical Assistants Society met for their Twentieth Annual Convention, April 23-26, 1970. Speakers for the sessions were: John Derr, MD, who discussed "The Growth and Development of Surgery;" Tommy Evans, MD, who discussed "What's New in GYN;" Benjamin Wailes, MD, discussed "Oncology;" and the Reverend Mr. Paul Blomquist who discussed "Priesthood of Personhood."

Elections were held at the April Convention and newly elected officers for the group are: President, Mrs. Patricia Austin, Washtenaw County; Vice President, Miss Margaret Broadwell, Wayne County; President-Elect, Mrs. Betty L. Boers, Kalamazoo County; Recording Secretary, Mrs. Arlene Bublitz, Bay County; Treasurer, Mrs. Ethel Lundgren, Genesee County; Speaker of the House, Miss Marlouise Redman, Wayne County; and Vice Speaker of the House, Mrs. Louise Murray, Muskegon County.

A Leadership Training Conference will be held September 26-27, 1970, in Ann Arbor. The hostess county is the Washtenaw County Medical Assistants Society. Miss Alice Budny, from Wisconsin, past president of the American Association of Medical Assistants, will conduct the morning session which will incluude duties of the officers, committee chairmen, and parliamentary law. Following Miss Budny's presentation, we shall divide into discussion groups which will be lead by officers and committee chairmen of the Michigan State Medical Assistants Society. The luncheon speaker is Joe D. Morris, M.D., whose topic will be "Cardiac Surgery."

The annual convention of the American Association of Medical Assistants will be held in Des Moines, Iowa, October, 1970. Delegates from Michigan are Betty Boers (Kalamazoo County), Ethel Lundgren (Genesee County), Marlouise Redman (Wayne County), and Patricia Austin (Washtenaw County). Alternate delegates are: Alta Greene (Calhoun County), and Louise Murray (Muskegon County). Michigan will be promoting two candidates; Miss Marlouise Redman for Vice Speaker of the House of Delegates of the American Association of Medical Assistants, and Barry H. Alford, MD. for the Advisory Board.

The Mid-Winter Educational Seminar will be held in Saginaw and the hostess county is the Saginaw County Medical Assistants Society. The theme is "EDUCATION—Your Passport to Knowledge." Speakers for the seminar are Teck Lian, MD, and William DeYoung, MD.

The American Association of Medical Assistants established a scholarship fund which is supported through contributions by the county and state societies. This year the Michigan State Medical Assistants Society is compiling a dessert cookbook and the proceeds from this project will be given to the scholarship fund.

We wish to thank you for the use of the Michigan State Medical Society's building in East Lansing for our Board of Directors' meetings. We also are most grateful to you for providing us with the services of Mrs. Jackie Van Deventer, Co-Ordinator, Women's Activities, MSMS.

Finally, an behalf of all of the members of the Michigan State Medical Assistants Society, we express our sincere thanks for your continuing support and assistance. Without your aid we would cease to exist.

12. Annual Report of Michigan Blue Shield — Robert H. Hamburg, MD, Chairman of the Board, and John C. McCabe, President

(The following report was presented in written form.)

The year 1969 was one characterized by ever-expanding benefits paid to more and more persons, but at the same time storm clouds were gathering. The particulars are contained in our annual report, copies of which are included for your attention.

This report is intended to give The Council and the House of Delegates details of the six-month period since that report was issued.

House of Delegates Resolutions

Following are the resolutions of the 1969 House of Delegates of MSMS which pertain to Michigan Medical Service, and the actions taken on them by the Board of Directors of MMS:

Resolutions 2, 9, 11, 21, 29 and 67 were considered together and a substitute resolution asked that Blue Shield's report to the patient of the non-participating physician be limited to a statement accompanying the payment stating that the payment represents the financial obligation of Blue Shield in this service. The Board took the following actions:

1. The "over-the-screen" letters to subscribers were discontinued by November 15, 1969.
2. Implementation of an intern system of handling over-the-screen cases, called "Alternative A" between November 15, 1969 and February 20, 1970.
3. Introduction of a new Pay Subscriber DSR in February 1970.

Resolution 12 was replaced by a substitute resolution urging MMS to continue to develop a method of notification of premium division to all Blue Shield subscribers.

This resolution was considered by the Professional and Public Relations Committee. Because quarterly rate filings and changes pose substantial practical problems; because Blue Shield certificates and billing notices are communicated by groups to their own members rather than by MMS; because the Blue Cross/Blue Shield ratio is changing and in many groups is now close to one-to-one; because there is no longer any public relations value; and finally because of cost implications, this resolution could not be implemented.

Resolution 15 requested that care of the newborn infant throughout the period of hospitalization be provided, regardless of the person attending at the delivery of said infant.

This resolution was considered by the Medical Advisory Committee. Because of current charging practices of physicians in this area, the existence of benefit for the new-born ill child, the likelihood of a well-baby care benefit being included in the near future and the impact on liability, the Medical Advisory Committee felt that implementation of Resolution 15 was not feasible.

The Medical Advisory Committee also considered Resolution 16 which requests that payment be made to physicians rendering anesthesia services along with obstetrical or surgical procedures when the service of an anesthetist or an anesthesiologist is not available.

Primarily because current charging practices of physicians are still inclusive of this service, and because of the impact on liability and inasmuch as a change in the contract language would be required, the Medical Advisory Committee felt that implementation of this resolution was not feasible.

Resolutions 24 and 26 were replaced by a substitute resolution requesting Michigan Medical Service to study premiums and fees to insure that the four socio-economic areas are equitable for all concerned.

The constant surveillance of all factors in the payment mechanism is the responsibility of the Medical Costs and Charge Patterns Committee of the MMS Board. The division of the state into four socio-economic areas is felt to be equitable at this time; periodic review of the matter is planned.

Resolution 28 requests that Michigan Medical Service conform to Resolution 37 of the 1969 House of Delegates of AMA, which states: "that under each program the terms 'usual, customary or reasonable' be properly defined and agreed upon by the physicians, the beneficiaries and the insurance carriers as developed by local determination so far as a physician's participation is concerned, and futher that any reference to 'paid-in-full' coverage clearly identify those services which are covered and the circumstances under which those services must be rendered."

The Board has accepted the report of the Public and Professional Relations Committee indicating that MMS is essentially in compliance with the AMA recommendation.

Resolution 32 reaffirms the House of Delegates' strong support of individual case participation.

This matter, of continuing interest to the Board of Directors, has been periodically reviewed. The Executive Committee has recently considered the issue; the qualified continuance of per-case participation is being recommended to the Board at its meeting of July 22, 1970.

Resolution 49 asked Michigan Medical Service to change its policy of "dunning" physicians in cases involving coordination of benefits and to direct future action for recovery of such fees to the subscriber.

This request has been implemented.

Resolution 66 asks that a formal invitation be issued to one or more members of The Council of MSMS to attend the MMS Board of Directors meetings and be a source of information to physician members of the Board and act as liaison between the Board and the State Society. It asks further for a schelude of these meetings and full information in advance of meetings.

The Board has complied with these requests.

Resolution 82 asked Michigan Medical Service to supply all pertinent details of the MMS Drug Program to all members of MSMS. This substitute resolution also covered Resolution 83 which directed a study of the propriety of MMS involvement in the Prescription Drug Program.

The Professional and Public Relations Committee reported to the Board that MMS had complied fully with the request; the Board concurred.

Resolution 84 was replaced by a resolution requesting modification of the present method of selection of MSMS physician candidates to the Board. It also asked that the Nominating Committee be appointed at an earlier date.

The Board has complied with these requests; a communication on these matters was sent to The MSMS Comcil on June 2, 1970.

Resolution 83 was replaced by a resolution calling for a change in policy of limiting the terms of physician members to the Board.

The Board has voted to remove the limitation of tenure for physician members of the Board.

Operational Statistics

BENEFITS PAID (In millions)

	1968	1969	Through June 1970
Regular	140.8	213.5	129.8
Medicare	47.9	53.4	28.6
Medicaid	31.3	36.3	20.9
ADMINISTRATIVE COSTS (In millions)			
Regular	12.9	16.6	9.2
Medicare	4.2	4.8	3.0
Medicaid	1.7	2.5	1.5

RESERVES (In millions)	41.3	6.8	(11.2)
INCOME RATIO (Regular)			
For Benefits	90.0%	107.8%	108.3%
For Administration	8.1%	8.4%	7.7%
EXPENSE RATIO (Per Service)			
Medicare—Benefits	8.94	9.24	8.71
—Adm. Cost	.79	.83	.90
(% of Benefit)	8.79%	8.96%	10.38%
Medicaid			
—Benefits	7.06	6.37	6.27
—Adm. Cost	.37	.43	.44
(% of Benefit)	5.27%	6.81%	6.99%
ENROLLMENT (In thousands)			
Regular	4,761	4,978	4,955*
Medicare	700	750	772*
Medicaid	326	416	460*
* Projected			
CLAIMS (In thousands)			
Regular (Inc. drugs)	3,812	5,361	4,787
Medicare	1,649	1,750	933
Medicaid (Inc. drugs)	2,089	2,736	2,557
PARTICIPATION (In percent)			
M.D.	65%	66%	*66%
D.O.	79%	80%	*81%
D.S.C.	81%	82%	*82%

	1st Qtr.	2nd Qtr.	3rd Qtr.	4th Qtr.
RATE INCREASES	16.7%	5.3%	15.9%	3.7%

---

* Since the Cost Stabilization Program was approved by the Board of Directors on March 18, 1970, Blue Shield has experienced a heavier than normal number of cancellations (152 as of July 1, 1970). During the same period, however, 167 new participation agreements have been received.

Corporate Structure

The Board of Directors of Michigan Blue Shield at a special session August 19, 1970 accepted by formal resolution the recommendation of the Executive Committee to seek amendment of Articles Four and Five of the Articles of Incorporation. Generally these articles provided that membership in the corporate body shall be comprised of all persons who are members of the House of Delegates of the Michigan State Medical Society, while the Board of Directors of the Corporation shall consist of 35 persons, 60 percent of whom shall be physicians and 40 percent of whom shall be public members.

Under the proposed amendments, the Board and Corporate structure of Michigan Blue Shield will be revised in this fashion:

The members of the Corporate body would be comprised of 51 representatives of those providing care; 45 persons from a cross section of the consumer population representative of purchasing groups, and 12 public members drawn from elements in the community not as directly involved in the process of medical care and its financing. Total Corporate membership would be 108.

The Board of Directors of 36 would represent a third of the total Corporation membership and would be drawn from the Corporate body in identical proportions to the composition of the Corporate body itself.

COMPOSITION OF FIRST BOARD OF DIRECTORS
UNDER PROPOSED STRUCTURE

Category of Membership	Corporate Body	Board of Directors	Minimum Number of Board Members To Be Drawn From Existing Board	Maximum "New" Board Members
MD's	36	12	6	6
DO's	6	2	1	1
Hospitals	6	2	1	1
Pharmacists	3	1	0	1
Total Providers	51	17	8	9
Representatives of Labor	9	3	2	1
Representatives of Industry and Substantial purchasing groups	36	12	6	6
Total Consumers	45	15	8	7
Insurance Commissioner Designees	6	2	0	2
Other Public	6	2	0	2
Total Public	12	4	0	4
TOTAL	108	36	16	20

Revised per Executive Committee 8/12/70

The proposed restructuring is the culmination of many months of extensive study of the need for change. Following are some of the facts and pressures suggesting the need for change:

Continued demand for greater public representation on the Board of Directors by major market factors, the legislature and the public at large.

Recent legislative action presented in the Kramer Bill is indicative of these demands for greater control of Blue Shield by the public and government in particular.

Recent changes in the National Association of Blue Shield Plans' Standards of Membership requiring adequate public representation.

The medical profession, consumers and government have voiced concern over the present Blue Shield Corporate and Board structure, and representatives of the profession as well as labor and the legislature have publicly expressed the need for Blue Shield to operate without direct control by the profession.

A statement on the need for change was given by John R. Ylvisaker, M.D., writing in *Michigan Medicine* in June, 1969:

"The medical profession has now reached a point in time when disentanglement from any formal relationship with Blue Shield is essential for each to remain untainted. Such disengagement need not involve ill will nor dissension. It should allow for a mutual consultative or advisory relationship."

Blue Shield began internal study of the possibility of change last year and the Executive Committee of the Board was formally assigned the task of analyzing reorganization in February.

Following are details on the restructured Board of Corporation:

Initial selection of the new Corporate membership will be by the Board of Directors.

Members of the Board of Directors will be elected by and from the membership of the Corporation.

Terms of *ex officio* members shall be coexistent with the terms of the office. Terms of members not designated "ex officio" are for three years with a provision for reelection.

Terms of Directors are to be for three years with at least one third being elected each year.

Meetings of the Corporate body are to be on an annual basis or on call.

13. Remarks of Spokesman for Medical Students Paul Werner

(The following Remarks were made on Tuesday afternoon.)

For several hours last evening, five of the medical student representatives at this assembly met to discuss what comments we would like to make this afternoon.

Marek Bozdech—Wayne State University,
Jeff Callen—University of Michigan,
Steven Rodis—University of Michigan,
Michael Shier—Michigan State University,
David Vanderwall—Michigan State University,

and myself prepared these remarks as a group, and I am honored to be able to speak for the six of us at this time.

Each of us extends to all of you his very sincere appreciation for the opportunity to sit in on your work and view the activities of the Michigan State Medical Society. Knowing little or nothing of the actions of this group before arriving, we have all learned much. We are impressed with the orderly and democratic processes whereby business is transacted. Equally impressive is the broad representation of Michigan practitioners and the high degree of participation of each of them. The free exchange of ideas, coupled with open-minded discussion, proved to us that here is an open forum for the discussion of medical problems and goals. We recognize here a demonstration of how rational men and women *can* make the democratic process work for them.

Our reception by the various reference committees has been overwhelming. The members of these committees actively sought student opinion on the various pending resolutions. You did more than just ask opinions; for, when given, our ideas were considered and sometimes incorporated into final decisions. This demonstrated that it is possible for the medical student to influence his elders and that these elders value our presence as more than just observers.

As medical students who are concerned with the professional aspects of many of the resolutions that you have considered, and as people who are concerned with the human impact of these proposals, we would like to commend you for your leadership in several areas:

The various resolutions making it easier for persons with drug and alcohol related problems to seek and receive help from the medical profession fulfill many of the ideals to which we ourselves subscribe.

We commend you for considering a resolution calling for the repair of damage to the Great Lakes. This shows us that you as practitioners are worried about one of the problems that we as students find intolerable—the destruction of the environment around us.

With pleasure we watched you consider resolutions that would expand and improve medical education in this State. You considered the establishment of well-funded departments of Family Practice at this State's medical schools, the reworking of the requirements for pre-medical education, and the shortening of the time required to produce a medical doctor.

And, perhaps most importantly, this body worked in many areas, in many ways to find the means that might bring more and better care to the medical consumers of Michigan. Several proposals to encourage the distribution of physicians to geographic areas of great need; other proposals to increase the output of family-oriented generalists; and a resolution that called for continued expansion of the medical school census revealed the high priority you place on the care of the patient. Furthermore, your thoughts on the role and training of paramedical personnel shows your willingness to explore the use of this means whereby time for patient care might be rapidly expanded.

In all of these areas we would strongly encourage your continued dedication in seeking workable solutions.

None of us realized that the main topic would be consideration of the relationship of the medical society to Michigan Medical Services. Therefore, we came like late spectators at a vigorous tennis match. We saw two sides hard at work but we were not sure how the game had progressed to this point. We must honestly admit that Blue Shield is not one of the issues that medical students now worry about. But, at the same time, we acknowledge that in a few years each of us *will* be involved and interested, and we thank you for the time, effort, thought, and study that you invested in the consideration of the Blue Shield program.

As I said earlier, we have all been impressed with the manner in which this assembly served as a true open forum for new ideas. Ladies and Gentlemen, you have shown yourselves open-minded and willing to listen to the thoughts of others. We are sure, that while you consider the areas that physicians find important, you are also willing to consider the areas that many medical students find important. Therefore, we readily insert some of these ideas in the open forum that you have created.

During this session, you have been asked to reaffirm the 1968 resolution on abortion. This resolution represents a significantly progressive stance on the question of abortion when viewed from the perspective of just a few years ago. But, as polls have shown, a majority of medical students believes that the decision on an abortion should concern only the patient and her doctor. The students feel that the decision to perform an abortion should be bound by the same considerations that determine the decision to perform any other operative procedure.

Students will be pleased to learn that you recognize the problems of drug abuse and approve the actions you have taken thus far to reduce the problem. They urge the continuation of programs that increase the drug education of the public and decrease the legal and social pressures that inhibit prompt and adequate treatment of drug abuse as a disease.

Most students view the medical profession as both an integral part of the system that can restore our environment, and a leader in the efforts to do so. These students would like to see organized medicine come down hard on environmental polluters and force them to clean up the messes they have made.

Students look with acute alarm at the unchecked expansion of the world's population. They watch as the rapid increases eat up the hard-won gains in medical care and physician numbers. We are convinced that organized medicine must actively campaign for zero population growth. This would allow for increases in the quality of medicine and a chance to bring medical care in sufficient quantity to areas that have not enjoyed such care before.

Medical students in Michigan are asking your help to decrease the disparity between the percentage of minority peoples in Michigan's population and the percentage of minority physicians serving the State.

Finally, we feel a responsibility to tell you that a sizeable minority of medical students view organized medicine with distrust. And, another large group of students are indifferent to organized medicine. Many of *us*—the six who wrote these remarks—in fact, came with negative impressions or, at best, indifference as to what would occur here. However, in the past few days we have seen the workings of this organization; we have heard the discussions; we have judged the proceedings. To our surprise, we found a vital, responsive, democratic group, actively endeavoring to better the practice and availability of medical care in the State. If a mere three days of exposure by observation could effect this change, we certainly feel that more active participation of student leaders in the Michigan State Medical Society would provide means of disseminating information concerning the society. And, it would provide tangible evidence that this society does value *and* evaluate student opinion in its actions. Therefore, we ask that you consider seating a student delegate from each of the medical schools as a full voting member of the House of Delegates each year.

Again, we each thank you for the excellent experience we have shared. I thank my fellow students for their aid in developing these remarks. And, we thank you for your kind attention.

REPORTS OF THE COUNCIL

14. Remarks of The Council Chairman — Ross V. Taylor, MD

You all have received in advance a printed report of The Council's activities to date. This report is a resume of actions taken by The Council on September 20.

The Council has under study a reorganization of the Governmental Relations Department and the Advisory Committee to the Director has interviewed four candidates with over 30 previously screened. An additional interview session is planned in the next two weeks.

The reports of the Councilors on their Councilor Conferences expressed unanimous approval from those attending the conferences that they should be continued. The Council is therefore recommending the continuation of the annual Councilor Conferences. Several districts have had additional conferences on a self-pay basis and several others have recommended additional conferences.

The Michigan State Medical Society has received notification that the Clara Elizabeth Fund is discontinuing its support of the annual MSMS Conference on Maternal and Perinatal Health which has been held annually in Flint. Other sources of financing are being sought.

Regarding 1969 House of Delegates Resolution 74, Medicare Freeze of Rate of Payment, The Council has taken some actions which bear reporting since the final decision is being referred back to the House. In December and January The Council corresponded with all members of the Michigan Delegation to the United States Congress. Replies were received from many. The pertinent details re the payment freeze were described in a letter from Robert Ball, Commissioner of Social Security, copies of which are available to the members of the reference committee.

At the same time MSMS Legal Counsel rendered an opinion at the request of The Council which pointed out the legal complications, cost projections and questions re the public relations aspect of initiating a lawsuit. Copies of this legal opinion also are available to the reference committee. Because of the cost implications The Council requested its Finance Committee to consider whether such an expenditure could be accommodated within the budget for this fiscal year.

The legal opinion indicates that institution of a suit concerning the freeze would probably be a fruitless endeavor. The Council therefore has referred the legal opinion and supplementary information back to the House for re-evaluation.

In transmitting this information to the House The Council reaffirms its opposition to and disapproval of the HEW action.

The Council was notified by Michigan Medical Service that HEW had again requested detailed information concerning those physicians who derived an income of $25,000 or more under the Medicare program, for the year 1969.

1969 House of Delegates Resolution 44 instructed that "MSMS undertake a full study to include all aspects, favorable and unfavorable, with all the ramifications of the feasibility of discontinuing our historical relationship with Michigan Medical Service." The Council referred this study to the Task Force which reported yesterday to The Council. The Council approved the report for transmission to the House. The report is printed and will be distributed to the members of the House this morning. Also distributed with the report will be an opinion of our legal counsel on this subject, rendered in 1968. An additional letter of information obtained for The Council is included.

THE REFERENCE COMMITTEE on Reports of The Council and Officers, E. E. Elder, MD, Chairman, recommended approval of the report.

THE HOUSE adopted the report of the Reference Committee.

Addendum:
Report of Task Force Committee of The Council
Re Resolution 44 of the 1969 House of Delegates

This Task Force Committee was appointed February 1970 by Doctor Taylor to study MSMS structure. This it has done and completed its report to The Council.

In June 1970, at the request of the Chairman of The Council, the Committee addressed itself to Resolution 44 of the 1969 House of Delegates, which directed that the "MSMS undertake a full study to include all aspects, favorable and unfavorable, with all the ramifications of the feasibility of discontinuing our historical relationship with the Michigan Medical Service;" and that "this report be presented to the next regular session of the MSMS House of Delegates."

Since the 1969 meeting of the House of Delegates, recommendations for radical changes in the corporate structure of Michigan Medical Service have been presented in the State Legislature, and more recently by the Board of the Michigan Medical Service. These recommendations will come before this House at this session, and are not considered to be germane to our report, although they naturally came into the purview of the Committee.

The Committee feels that it can best discharge its purpose by:

1. A short review of the historical relationship of the Michigan State Medical Society and the Michigan Medical Service.
2. Summary of the pros and cons of continuing the historical relationship between the Michigan Medical Service and the Michigan State Medical Society.
3. A review of the function of the Corporate Body and some of the legal instruments which govern the procedures and control of the Michigan Medical Service.

1. The Michigan Medical Service was established in 1939 on the basis of an Enabling Act (M.P.A. 108-1939) passed by the State Legislature to provide for and to regulate nonprofit medical care corporations.

The Articles of Incorporation, or association of the Michigan Medical Service, created the corporation. The incorporators were all physicians of Michigan.

The Articles of Incorporation define the composition of the Corporation, and the composition of the Board of Directors. They provide that the Articles of Incorporation may be amended at any annual meeting of the Corporation, or at any special meeting provided that 15 days notice has been given to the members. Such changes must be approved by the Commissioner of Insurance, as provided in the Enabling Act.

The By-laws of the Michigan Medical Service are adopted and changed by the Board of Directors. The By-laws provide that the directors shall be elected at the annual meeting of the Corporation.

The "Service Principle" of the provision of medical care was an integral part of the Michigan Medical Service Program. This provided that subscribers with a family income level of below $1,500 would be accorded certain medical services, by participating physicians, without additional cost. The fee schedule, developed by the Michigan Medical Service, to pay physicians for these services was admittedly low, but was acceptable to the profession because of the profession's traditional care of low-income patients at reduced or no charges.

In February of 1945 the so-called service family income level was raised to $2,500, this being the total family income.

In October of 1950 the service family income level was raised to $5,000.

In May 1958 the $7,500 service level was approved. This was not a family income level, but that of an individual member of a family.

Fees to doctors providing the medical services were increased with each elevation of the service level but the fee increase was not comparable to the service income level change. The agreement with the participating physician during these times was, that if the income, of an individual or of a family, was below the then-specified level the service would be provided at the fee schedule published by the Michigan Medical Service. If the income of the individual or family was above the then-specified level, the physician was free to charge a fee which he considered proper.

As the income level changed from $1,500 to $7,500 there were increasing numbers of individuals in the so-called service group.

In an effort to resolve problems which were apparent with this program, the Variable Fee concept was adopted. For reasons beyond the scope of this review, to maintain the financial integrity of the Michigan Medical Service, it was necessary for that corporation to recently adopt a fee schedule which is less than the usual and customary physician's fees. This change has also been reflected in the Medicare and Medicaid payment levels.

Another change which has occurred over the years is that the subscriber has tended less and less to be an individual who purchased a contract from the Michigan Medical Service. He is more and more represented by groups. The premium for these groups has increasingly been paid by employers, some of which are very large corporations. The provision of the health care contract has been a fringe benefit of the workers' employ. The cost of the contract is of critical concern to the employer, and the benefits of the contract are of critical concern to the employer and employee, as represented by his union. Both of these groups have recently had representatives on the Board of Directors of Michigan Medical Service. The subscribers covered by the Michigan Medical Service now represent about half of the citizens of Michigan. During the past year there has been evidence of interest in greater public control of the policy-making body of the Michigan Medical Service, which has concrete expression in a bill before the State Legislature.

2. The Committee considers that, if the historical relationship between the Michigan State Medical Society and the Michigan Medical Service were discontinued, no official relationship would exist. This is not to say that doctors of medicine might not serve on the policy-making committees, nor that advisory committees of the MSMS would not meet with similar liaison committees on the Michigan Medical Service or of any other insuring agent. But the Michigan Medical Service would not be associated with the MSMS in the sense that its comporation is provided by the Delegates of the MSMS, and that its physician directors are nominated by committees of the MSMS, and that Michigan Medical Service would no longer be the "doctor's plan." Relations between the medical profession and the Michigan Medical Service would be on a purely individual basis.

The Committee considered advantages of this type of disassociation to be as follows:

1. The physician's relation to the Michigan Medical Service would be the same as his relation to any other insuring agent—A basic professional and financial relationship would exist between the physician and the patient. A financial-insurance relationship would exist between the patient and the Michigan Medical Service.
2. The fiscal policies of the Michigan Medical Service would not be an indirect responsibility or concern of the MSMS, and the physicians of Michigan would be relieved of the public impression that fiscal policies of the Michigan Medical Service are dictated by physicians.
3. Physicians' services and fees could not be a negotiable commodity in the labor-industry market.
4. The matter of fees for medical service could be in part returned to the control of supply and demand.
5. Physicians would not be in the position of subsidizing underwriting discrepancies by arbitrarily reduced fees for service. Premiums appropriate to the scope of benefits could be derived which would be fiscally sound and financially stable.
6. Deductible or participation contracts might be provided, which would on the one hand reduce premiums, and on the other, exercise some control on utilization.
7. A new program might return to the consumer and the physician the right of assignment.
8. The subscriber, or patient, would deal with the insuring agent rather than the physician, and the physician would have more time to care for his patients.

Disadvantages of disassociation are considered by the Committee to be as follows:

1. Michigan organized medicine, which represents most of the providers of professional health care, would lose a direct influence on policy formation of the Michigan Medical Service; in this respect on social forces as exercised through health care.
2. Fee collection would be returned to the responsibility of he providers of service. In this sense dependence on third party fee collection would be relinquished.
3. Disassociation in one stage might later be considered to be ill-advised, leaving the physicians of the State in a less desirable situation. Withdrawal of the sanction of the MSMS from the Michigan Medical Service could leave a void which could be filled by influences which are much less acceptable than the Michigan Medical Service.
4. Public relations may be adversely affected by withdrawal of the historical relationship, since the Michigan Medical Service was originally conceived as a community service by providing a medical service plan for low-income families.
5. Disassociation might jeopardize the financial security of the Michigan Medical Service, since its service aspect appeals to large groups of consumers, and to many who would control the provision of medical care.

3. Article IV of the Articles of Incorporation define the make-up of the membership of the corporation, also that the annual meeting of the corporation shall be held in September at a time fixed by the Board of Directors.

The By-laws, Article 1, Section 2, state that special meetings of the members of the corporation may be called on written request of ⅓ of the members of the corporation, by a majority of the Directors or by the Chairman.

Article II, Section 1, of the By-laws specifies that the Directors of the corporation shall be elected at the annual meeting of the members.

Article Ten of the *Articles of Incorporation* provides that:

"The Articles of Association may be amended at any annual meeting of the corporation or at any special meeting, provided that 15 days' notice of the proposed amendment has been given to the members. No such amendment shall be effective until it has the written approval of the Commissioner of Insurance."

Article XI, Section 4, of the By-laws defines the function of the Board of Directors who have the control of the business, property affairs and management of the Corporation. The By-laws of the Corporation may be amended by the Directors.

In summary, The Corporate Body elects the Directors who run the corporation. The Corporate Body may amend the Articles of Incorporation at any regular or special meeting if 15 days' prior notice is given.

The Committee presents no recommendations since the resolution requested a Study Committee.

James B. Blodgett, MD, Acting Chairman
Ross V. Taylor, MD, Co-Chairman

15. Report of Council Activities

Part I

These white pages report in capsule style the highlights of The Council's work during 1969-70 in the usual ongoing areas of MSMS service, such as legislation, communications, postgraduate medical education. Three subjects have been separated and expanded in Part II of The Council report—Michigan Medical Service; government-Medicare-Medicaid; and the MSMS Management Study.

In Part I, The Council wishes to point to some general activities in brief; detailed reports being unnecessary since minutes of The Council's meetings are mailed regularly to Delegates and component medical society leaders, and abstracts of Council actions appear regularly in *Michigan Medicine*. Delegates or county officers with questions about items that follow are urged to immediately contact their MSMS Councilor or the MSMS headquarters staff.

MSMS Membership

Membership in MSMS on December 31, 1969, stood at 7,979—the highest figure in history. The gain over the previous year was modest, but many other professional societies are experiencing declining membership. The June 1970 membership is virtually the same as the June 1969 figures. Following are the MSMS membership figures:

Year	*June 30*	*December 31*
1935	3410	3543
1945	4425	4686
1955	5503	6109
1960	6660	6715
1965	7247	7563
1966	7296	7710
1967	7301	7858
1968	7617	7951
1969	7644	7979
1970	7643	

Membership Services

Study Underway: A survey is being completed this summer to learn what membership services are offered by other state medical societies and by component societies of MSMS. These ideas will be adapted for possible expansion of MSMS benefits re life insurance, financial assistance to elderly physicians and to physicians' widows, etc.

MSMS Group Insurance Programs: There were two major developments this year in the MSMS group insurance program: The implementation of a Society-sponsored plan of umbrella-type excess liability insurance, and action to increase the available limits of group life insurance from $10,000 to $25,000.

The new "umbrella" coverage became available this spring to provide excess liability coverage above basic insurance in amounts of $1,000,000 to $5,000,000, applicable to professional liability, office premises, automobile, residence, etc. An excess major medical feature that supplements a basic health plan also was added.

A valuable advantage of the MSMS plan is the low requirement for basic professional liability insurance of $100,000/$300,000. Many similar plans require $200,000/$600,000 professional liability limits, which result in higher premium costs. The premium cost for the MSMS plan is less than comparable plans.

Survey on Professional Liability Insurance: As directed by the House of Delegates, The Council this spring sent a survey questionnaire to members (excluding those previously surveyed by the Wayne County Medical Society) on specific problem areas dealing with professional liability insurance.

The survey asked for information about type of practice, limits of liability, premiums, problems encountered in obtaining coverage, claims, suits, and suggestions that might reduce the cost of obtaining adequate coverage.

The results of the survey are now being tabulated and will be reported in Part II of The Council's Annual Report. Armed with this information, The Council hopes that representatives will be able to meet with the Michigan Insurance Commissioner and other interested parties to discuss possible solutions to these ever increasing problems.

The Professional Insurance Committee is also meeting with the AMA in order to learn first-hand what AMA progress toward finding a national professional insurance carrier has been made.

Streamlining Committee Activity

The Council is making an overall review of its efforts, commitments, and available resources. This is reported in more detail in Part II where Planning and Priorities are discussed.

But, in the everyday operation of MSMS, committee activity plays an important and consuming role. The Council, with staff, is making a serious effort to streamline and revitalize the MSMS committee structure, utilizing the advice and guidance of current chairmen. We are exploring the possibility of combining certain committees under commissions. We are attempting to avoid duplication of effort and focus our efforts on the most critical issues of the day.

Whatever decisions are made will be implemented, with House permission, on an experimental basis and formal recommendations for permanent change will be made to the 1971 House along with any Bylaw amendments that may be required.

Executive Secretarial Service

In its last report, The Council indicated it was offering an Executive Secretarial Service to outside, but related, health organizations or specialty societies.

The first account, for a one-year trial period, was the American College of Emergency Physicians. MSMS provides executive secretarial services to the association, serving as its headquarters office. For this MSMS is reimbursed for the secretary's time plus profit and overhead.

The arrangement has worked out well, and inquiries regarding similar arrangements have been made by two specialty organizations.

Medical Economics

Relative Value Study: The House authorized The Council to reprint the Michigan RVS, but after considerable discussion at several committee meetings and full Council sessions, it was decided to defer consideration of this item until some future appropriate date because the AMA had just published the 2nd Edition of its CPT (Current Procedural Terminology) with a five digit number coding.

The AMA reports that the new CPT is being studied by many insurance carriers and government agencies for possible adoption as the standard system for reporting medical services. The Council, at its July meeting, endorsed the revised CPT as the best description and coding of medical services that is available.

Medical Economics: In a new approach to obtain more thinking and guidance about medical-socio-economic matters, two workshops were held in the spring. They combined three MSMS committees—the Committee on Medical-Socio-Economics, the Committee on Governmental Medical Care Programs, and the Committee on Public Relations. The three groups studied both the costs of medical practice and of medical care in Michigan, and dealt directly with two specific matters. Recommendations will be made by The Council to the House of Delegates on these matters: (1) the implementation of Substitute Resolution 5 of the 1969 House of Delegates to establish a counseling and negotiating service; and (2) the question of obtaining statistical evidence about the health needs of people in the inner city and the related questions of how best to meet these needs.

Assistance re Inner City Study: The Council referred to the Committee on Governmental Medical Care Programs a request from Wayne County Medical Society to seek "MSMS assistance in surveying the medical needs, facilities and services now available in the Inner City of Detroit." Statistical and analytical data were collected and transmitted to WCMS.

Legislative Affairs

Legislation: The 1970 legislative session has been characterized by an intensive effort on the part of the Michigan Legislature to clear the calendar in order to begin preparations for the fall elections. With the number of bills introduced surpassing all previous years, the Legal Affairs Committee has had to carefully screen proposals for those with medical implications.

The progress of legislation having primary importance for the medical profession has been reported to MSMS members through *Michigan Medicine*, the *News Extra*, and *Medigram.*

Before adjourning for a summer recess, both the House and Senate gave approval to the Basic Science Amendment, endorsed by MSMS. MSMS has urged outright repeal of the Basic Science Law for several years, but legislative efforts this year were directed toward amending the law as a partial solution to the problem of the outdated law. HB 4059, as amended, will exempt graduates of accredited medical schools in the United States from taking the basic science exam. It is hoped that such an amendment will make the State of Michigan more attractive for physicians and will help alleviate the state's shortage of doctors. The basic science exam will now only apply to MDs, DOs and chiropractors who are educated in foreign countries.

Other health items which were approved by both legislative chambers and sent to the governor include HB 3363, requiring the immunization of preschool children against rubella; a bill to permit the temporary retention of an abused child; and revamping the basis for creation and appointment of the Advisory Council for Mental Health Services.

Five pieces of legislation sponsored by MSMS are still eligible for action when the Legislature reconvenes after the August 4 primary. They include proposals dealing with: (1) confidentiality of medical records, (2) extension of the Good Samaritan law to ambulance personnel, (3) public health officers liability, (4) state public health officer qualifications and (5) amendment to 1969 law regarding minors consent to treatment for VD.

The Council accepted, with regret, the resignation of MSMS legislative counsel M. A. Riley in April of this year. Mr. Riley had been the primary staff person involved in legislative affairs and his 10 years of consistently valuable performance will be missed by the Society.

A sincere vote of thanks is due the physicians who have labored so hard on the Legal Affairs Committee, especially chairman Otto K. Engelke, M.D. The Council also expresses its deep appreciation for the supportive efforts of the individual physicians throughout the state who, when called upon to express medicine's views to individual legislators, responded magnificently and with good effect.

Volunteer Lobbying Program: 1970 launched a new legislative project for MSMS, utilizing the talents of physicians in the lobbying efforts in Lansing. Recommended by the Legal Affairs Committee and approved by the 1969 House of Delegates, the program involved one volunteer physician each week representing the medical profession in the State Capitol.

Nineteen volunteers were selected out of approximately 65 responses to become members of what had been dubbed "Medicorps." They were chosen on the basis of representation in the Legislature which yielded the following distribution: 4 men from Wayne; 3 from Oakland; 2 from Kent; 2 from Ingham; 1 each from three middle-sized societies (Macomb, Saginaw and Bay-Arenec-Iosco); and 1 each from five smaller societies (North Central, Delta-Schoolcraft, Barry, Gratiot-Isabella-Clare, and Newaygo).

Each volunteer lobbyist arrived in Lansing Monday afternoon for a "briefing" session at MSMS headquarters. During this session he was given material related to legislation pending that week, his schedule of meal engagements, and other information for his use during the week. Throughout the week close contact was maintained with MSMS staff in order to supply the physician with any additional information he may have needed. Friday morning concluded the week with a "debriefing" session again at MSMS.

The program has been a very successful endeavor, with participating physicians and legislators expressing approval. Members of the Michigan legislature have particularly appreciated the opportunity to seek the professional opinions of a physician when dealing with health-related legislation.

MSMS is the only state society to conduct such a volunteer lobbying program and several major publicity pieces have been written as a result. The Council thanks the 19 physicians who took time from their practice to support the legislative efforts of the Society by participating in the program.

The program will continue in 1971.

Postgraduate Medical Education

MSMS continued to provide many postgraduate medical educational opportunities to members.

1969 Annual Scientific Session: The Session in Detroit, September 24-25, drew more participants than the year before while many other medical meetings have experienced a drop in attendance. Topics of importance to the everyday practice of medicine were covered by speakers, and four all-day seminars covered subjects in depth.

Michigan Medicine: The official publication of MSMS earned the praise of independent graphic designers at two national publications conferences for its attractive format and carefully chosen articles. The journal continued to provide authentic scientific material, chosen by Scientific Editor John W. Moses, M.D., Detroit; and short, to-the-point articles about MSMS activities and projects.

Fall and Spring Programs for Component Medical Societies: The programs were provided by MSMS with the cooperation of the three medical schools and the Michigan Department of Public Health. For the first time, MSMS provided programs last fall in only those communities where the county medical society was interested in developing a wet-clinic-type program at a local hospital. MSMS sent medical educators from the three schools to the afternoon clinical programs; and to stay for formal evening presentations. This new approach was continued for the Spring 1970 series.

Special Conferences: To further meet responsibilities in continuing medical education, MSMS sponsored the Ninth Annual Conference on Maternal and Perinatal Welfare in Flint, and the Fifth Annual Conference on Medical Aspects of High School Sports at Ann Arbor. MSMS committees developed the programs, which drew fine audiences.

MSMS-MARMP Pilot Project: MSMS and the Michigan Association for Regional Medical Programs are cooperating in a small project at two Upper Peninsula hospitals to send selected Michigan medical educators and practicing physicians into the two communities to help the physicians improve their care of heart patients.

Study of Mandatory Continuing Education: The MSMS Committee on Postgraduate Medical Education spent considerable time in study and discussion this past year on the question whether continuing medical education should be mandatory as a provision for membership in MSMS and/or for recertification by the state. The study is continuing.

Professional, Public Relations

MSMS efforts this past year to inform, to educate, to influence took many directions with many physicians, staff members, and friends playing prominent roles. The following short notes touch on some of the major efforts:

Liaison with Component Societies: For the first time in several years, the MSMS president toured the state to meet in shirt-sleeve, working sessions with the officers of component medical societies. The Society thanks President Robert J. Mason, M.D., for his special efforts to listen to problems and proposals and to describe MSMS efforts in legislation, education, public service, etc. An effective workshop for component medical society leaders was held in the spring at MSMS headquarters. Throughout the year, MSMS provided special information to component society leaders through periodic letters and through *Michigan Medicine.*

Liaison with Other Organizations: Cooperative projects and communications efforts have been carried out by MSMS with a growing number of organizations, such as the Michigan Health Council, Detroit Medical Association, the Student American Medical Association chapters at the three universities, Michigan Public Health Officers Association, Michigan State Pharmaceutical Association, State Bar of Michigan, Michigan Press Association, Michigan Congress of Parents and Teachers, Michigan Youth Commission, Michigan Council of Churches, and many others. The MAP weekly television program, "Formula," presented many physicians and medical topics during the year.

Liaison with Woman's Auxiliary and Medical Assistants: MSMS continued its arrangement to provide staff assistance to the Woman's Auxiliary to MSMS and to the Michigan State Medical Assistants Society. These two groups are especially helpful to MSMS in its legislative and communications efforts.

Liaison with Specialty Organizations: Several of the medical groups—Michigan Society for Internal Medicine, Michigan Academy of General Practice, Michigan Health Council, American Cancer Society, American College of Emergency Physicians, MSU—U-M Cardiovascular Research Clinic, Michigan Association for Regional Medical Programs, Association of Graduate and Postgraduate Educators, and Michigan Heart Association utilized the MSMS building for meetings. All groups are involved in planning portions of the annual scientific session.

PART II

Management Study

Last year, The Council recommended and the House approved a management study by the Alexander Grant organization to review the MSMS staff and to receive any recommendations for improving, streamlining and increasing the efficiency of the MSMS management.

The management study was under the responsibility of the MSMS Task Force (Speaker James B. Blodgett, MD, Acting Chairman). The Alexander Grant report was presented to the Task Force in May and to the full Council on May 27. The Council approved the study recommendations. (Attached is Addendum A, the introduction to the study, and Addendum B, a proposed interim organization.)

Coincidental with the adoption of the study recommendations, Hugh W. Brenneman announced his intention on May 27 to run for political office. At the May 27 meeting of The Council, Warren F. Tryloff was appointed Director of MSMS. On June 17, therefore, Mr. Brenneman announced his resignation as Executive Director of MSMS in order to campaign for the State Senate.

Addendum B shows the resulting recommended staff organization. The Director is at the head of a businesslike management staff, which reports directly to him. The rest of the operation is under three managers; i.e., Government Relations Department Manager, Communications and Professional Information Department Manager, and Operations and Economics Department Manager. The staff was organized this summer along traditional vertical report lines which provide for a clearer understanding of responsibilities, holding each manager responsible and accountable for the objectives and activities within each department.

The reorganization of the staff was completed in late June. It resulted in the elimination of one clerical position. As of this writing, the managers of the departments are: Government Relations—Stewart Kerr (Acting Manager); Communications and Professional Information—Herbert Auer; Operations and Economics—Richard Campau.

The Council is actively seeking an outstanding candidate for the manager of the Government Relations Department. At this writing, several candidates are being considered, but in the interim the department has the expert advice and guidance of Mr. Kerr during these months of low legislative activity. This allows The Council adequate time to obtain the best possible department manager.

Mr. Campau rejoined MSMS to head the Operations and Economics Department. Responsibilities of this department will be postgraduate education, Annual Session, House of Delegates, exhibits, Regional Medical Advisory Committees, and the general day-to-day administrative operations of the Society. MSMS was fortunate to obtain the services of Mr. Campau because he has broad knowledge of the internal operations, through his previous employment.

Mr. Auer now truly becomes head of the Communications Department with total responsibility for the public relations effort of MSMS, plus *Michigan Medicine* and liaison with other related organizations.

Because of the restructuring of the staff, it was possible to redefine the job descriptions of the employees and to turn over certain responsibilities to other members of the staff, making it possible to eliminate one full-time position. Therefore, Mr. Ralph Wills accepted early retirement as of September 1 and his former duties will be assumed by other members of the staff.

While the management of MSMS has been streamlined and the potential for efficiency highly increased, a great deal of work needs to be done. Mr. Tryloff is faced with the responsibility of incorporating and implementing the detailed recommendations of the management study in relation to personnel policies, salary administration, etc., etc.

The Council believes that the management study was most worthwhile and fits in, in time and importance, with both the short-term and long-range planning that is now going on within the Council structure.

The original cost estimate for the study made by the Alexander Grant Company was $5,000. As the study progressed, its scope was enlarged slightly because of some additional problems that were discovered in the process of the study. In addition, personal reports by key members of the Alexander Grant staff to the Task Force and to The Council were not anticipated in the original budget estimate. Therefore, there was an over-run in the cost of the study, partially due to errors in the Grant estimate and partially due to the increased reporting procedures which were requested by MSMS. This was resolved by a settlement mutually agreed upon by MSMS and the Alexander Grant Company. The total cost was $7,500.

The Council's Long-Range Planning Efforts

During the past year, The Council created a Committee on Planning and Priorities which has the establishment of long-range MSMS objectives as one of its major goals. This Committee agreed to 1) review current purposes of MSMS, 2) study the problems facing medicine and MSMS members, 3) review efforts to solve these problems, 4) determine the effectiveness of these efforts, and 5) decide if more needs to be done.

In its initial efforts, the Committee is taking a long look at the complicated structuring of The Council and its committees, indeed, all committees of MSMS. This study is in conjunction with the committee review undertaking by the two appointing officers—The Council Chairman and the President of MSMS.

The Committee's purpose, in general terms, is to develop a plan for the activities of MSMS and to recommend priorities according to the relative importance of each, taking into consideration available resources of MSMS. This is a broad charge and the Committee may make any sort of recommendation that has to do with MSMS programs and MSMS financial and staff resources. The Committee is in the process of developing a list of the most crucial current issues which concern the MSMS membership. The Committee then will try to rank the list in order of importance, determine what can be done in each of these categories, and then estimate the financial and staff requirements of the various projects in order to balance the priorities against available resources.

The Council believes that planning for the immediate and distant future is one of the most necessary continuing responsibilities of The Council.

The work of this Committee and of The Council will lead to a re-evaluation of all the activities of MSMS, and probably the elimination of some of the traditional activities of the Society, to be replaced by problem-solving efforts on more contemporary issues. This will have an effect on the financial future of MSMS, the attractiveness of organized medicine to new physicians graduating in the future, and, in fact, a vital effect on the whole future of the state medical association in the next decade.

Finance

Income and expense estimates for 1970 are going very much according to plan. The increase of 1970 budget over 1969 budget was within the range of the cost-of-living increase, approximately 7 percent. Income, of ocurse, increased markedly, because the 1969 House of Delegates adopted a dues increase.

The Finance Committee set aside a portion of the 1970 dues income for use in the 1971 budget year and the 1972 budget year, since it anticipates increased costs during those years, too.

Experience during the first seven months indicates that the picture has improved regarding advertising income from *Michigan Medicine*. The downward trend over the past several years has been halted and 1970 advertising income will equal or surpass 1969.

The 1969 House of Delegates specifically asked The Council to evaluate 1969 Budget Item "TV News Releases and Radio Series," which in 1969 carried an expenditure of some $11,000. It was reviewed by the Finance Committee in January, 1970, and a budget figure of $14,000 was set. The Finance Committee was confronted with the fact that the programs were being accepted by broadcasters and the news media, although the Committee still questioned its value to MSMS. Therefore the Finance Committee agreed to continue the programs for 1970 with a full review before the 1971 budget was developed.

Subsequently, upon Mr. Brenneman's resignation to run for political office, the television program "Formula," produced by the Michigan Association of the Professions, was taken over by the Michigan Health Council and therefore is being operated at no expense to MSMS.

The continuation of the radio series is under investigation by the MSMS Communications Department. It is expected that a low-cost plan for utilization of the mass media will be developed for the 1971 budget.

All in all, the Finance Committee expects that the budget will be in balance at the end of the 1970 fiscal year.

Following is a balance sheet for the eight-month period ending July 31. It shows the status of our assets and liabilities and the resulting members' equity.

BALANCE SHEET
July 31, 1970

CURRENT ASSETS		
Cash	$79,844	
Accounts Receivable	20,362	
Pension Trust & Due from Employees'	11,255	$ 111,461
INVESTMENT IN SHORT TERM SECURITIES		$ 291,923
INVESTMENTS IN FUNDS		
Capital Reserve Fund		261,600
Capital Protection Fund		382,767
FIXED ASSETS		
Building	$606,235	
Furn. & Equip.	102,704	
Less: Accumulated Depreciation	137,864	571,075
Land		75,971
OTHER ASSETS		
Time Certificates (Funded Obligation to Retired Exec. Dir.)		35,759
Accrued Interest Receivable & Prepaid		600
		$1,731,156
CURRENT LIABILITIES		
Mortgage Payable (Mich. Nat'l Bank)		$634,790
Accounts Payable (Est.) (Includes AMA Dues)		18,000
Property & Other Taxes Payable (Est.)		8,000
Long Term Liability Retirement Fund (Wm. J. Burns)		35,000
MEMBERS' Equity (Net Worth)		1,035,366
		$1,731,156

The investment funds will be described in detail in the Treasurer's Report.

Other portions of this report describe Council efforts to make long-range plans 1) to streamline and increase the efficiency of our staff, 2) to re-evaluate our activities, and 3) mobilize our energies and finances for the more critical issues that are relevant to the times. This may have a far-reaching impact upon our financial commitment. Certainly we can expect to save money in some areas and we may find it necessary to increase our budgetary expenditures in certain other areas of interest.

The 1969 House of Delegates directed that the MSMS Directory of Members be printed only every two years as an economy measure. The usual annual cost of printing the Directory has been more than $6,000.

The Publication Committee of The Council considered this entire matter and concluded that, because of the large volume of changes in membership each year, such a biennial directory would be almost useless in the second year.

After exploring many possibilities for reducing costs, the Committee agreed that, by using the offset process and listing members' names alphabetically rather than by component society, costs could be reduced to approximately $3,200 annually. The Council approved the Committee recommendation that the House be requested to consider this matter again and authorize an annual MSMS Directory. A resolution on this subject will be introduced for The Council.

Government Relations
Medicare-Medicaid

The Council during 1969-70 continued to support the profession's concern about fair and reasonable reimbursements to physicians for their services.

MSMS Council Chairman Taylor was selected in the fall by the AMA as the only state society spokesman to testify at an HEW hearing in Washington. He made several suggestions for controlling medical costs, and he cautioned that fee ceilings could prevent proper patient care.

The Council approved sending letters to Michigan Congressmen expressing MSMS concern about placing ceilings on fees and requesting their opinion on the legality of such a ruling by HEW.

The Chairman, selected physicians, and staff met with the State Senate Finance Committee to discuss Medicare payments to physicians who reportedly received more than $25,000 during 1968. MSMS issued public statements denouncing the unfounded allegations of widespread abuse and fraud by Michigan physicians which reflected on the reputation of the overwhelming majority of ethical physicians who practice medicine.

Physicians were urged to use their customary restraint in considering increases in charges for professional services; and to base any changes in charges on their own increased overhead.

Comprehensive Health Planning.

Although Medicare and Medicaid continue as the major federal programs for delivering health care to certain eligible persons, the Government continues its support of comprehensive health planning and MSMS Council involvement has increased markedly.

The State Agency invited MSMS to submit a statement about this program for publication. The Council responded that it continues to support the concepts of comprehensive health planning to the extent that it encourages and seeks to expedite more coordinated community planning. The Council's statement cautioned that the profession's confidence would continue only if the profession is allowed to be an active participant on a partnership basis. MSMS suggested that such partnership could be assured by increasing the number of practicing physicians on the Advisory Council to provide increased professional medical guidance.

The Council approved a recommendation that an appeal mechanism be available to allow any aggrieved public or private agency to be heard on adverse rulings. Such appeals are now permitted under State Executive Order 1970-1.

The State Advisory Council has proposed franchising legislation which does not totally conform to the policy adopted by The Council of MSMS in 1965.

Payments to Chiropractors.

The Council several times took official action to oppose further efforts by chiropractors to obtain payment under Medicare or under Michigan Medical Service contracts.

The Council objected to an opinion issued by the Michigan Attorney General to the Michigan Department of Social Services that chiropractors are considered physicians and must be paid for providing care under Medicaid. The Council sent letters to state and federal officials noting that chiropractors were not physicians under the federal Medicare law and, therefore, were not eligible to participate.

The Council took action to oppose a bill in the Michigan Legislature that would allow chiropractors to be paid under Michigan Medical Service. The bill was not adopted by the Legislature before its recess on July 3. (Blue Shield contracts to date have not paid chiropractors for services.)

Regional Advisory Committees.

The Council approved recommendations by its County Societies Committee outlining areas of concern in establishing regional advisory committees which would benefit from MSMS policy direction.

Nursing Homes.

The Council informed the Michigan Department of Health of objections to Rules 52, 53 and 57 of the MDPH Administrative Rules for certifying licensed nursing homes for participation in various government-sponsored health care programs. MSMS also objected to the wording in Rule 54 regarding countersigning of telephone or other verbal orders by the physician "within 72 hours" and requested that it be amended to read "on his next visit."

Relationship With Blue Shield

The Council has continued its policy of inviting Blue Shield officials to report regularly at meetings of The Council; and The Council has appointed Ralph R. Cooper, MD, as official representative to the Blue Shield Board meetings.

Two major areas of concern this year have been 1) controversies arising from the new Blue Shield non-participating physician Doctor's Service Report (DSR), especially as it applies to "prior agreements" and the legal ramifications thereof, and 2) the establishment by MSMS of a viable peer review mechanism to assist and advise Blue Shield in the review of claims, the arbitration of fee disputes, and the review of utilization frequency and charge patterns.

Because of legal difficulties, many of the problems arising out of "prior agreements" have not been solved. The Council has notified Blue Shield that the revised DSR is highly objectionable, and MSMS will continue its efforts to bring this matter to a satisfactory conclusion.

Concerning peer review, Regional Medical Advisory Committees have been formed in all Councilor Districts and the MSMS Committee on Utilization Review and Health Insurance Problems has been established. Complete information on this new program was sent to component medical societies in February and Blue Shield has been notified of the three steps in the peer review process: First, Blue Shield should contact the physician and review the problem with him; if this does not solve the situation, then second, refer the problem to the component society for committee review; and third, if necessary, Blue Shield should refer the problem to the MSMS Regional Medical Advisory Committee. Finally, decisions of Regional Medical Advisory Committees may be appealed to the MSMS Committee on Utilization and Health Insurance Problems which will handle such appeals in addition to the other functions with which it is charged.

As directed by The Council, the Committee on Utilization Review and Health Insurance Problems studied the statement contained in Resolution 85 of the 1969 House of Delegates pertaining to reimbursement of physician members of the Blue Shield Board. This Committee's report to The Council contained a recommendation that The Council recommend to the House of Delegates that MSMS *not* reimburse physician members of the Blue Shield Board. The Council approved the Committee report at its July meeting. The Council's recommendation on this matter will be contained in one of the resolutions that will be introduced on behalf of The Council by the immediate past president.

Blue Shield has asked for Council endorsement of its cost-stabilization program, which was described in a briefing on April 15, 1970, for selected leaders of the medical profession. Essentially, this program would reduce certain prevailing screen levels as contained in the following proposal which had been adopted by the Blue Shield Board:

"1. 76 high frequency surgical procedures were reduced in all areas. These would affect both generalists and specialists. Of these 76 procedures, 28 procedures were of the type that called for Technical Surgical Assistance, and therefore these were reduced also.

"2. In the case of Inpatient Medical Care, it had been historical in Blue Shield that performance in terms of participation in and acceptance of the program by internists have been lower than desired, therefore, while some reductions were noted on inpatient medical care for generalists and specialists, such decreases were less in the case of internists.

"3. In anesthesia, the prevailing levels were reduced in all the areas except the Upper Peninsula (Area D). In diagnostic X-ray 48 procedures were reduced back to the level they were in November, 1968, and therefore, provided uniformity by corresponding to the Medicare and Medicaid prevailing levels.

"4. Other benefit categories, such as therapeutic X-rays, deliveries, consultations, and psychiatry were not modified. These were left unchanged because of moderate prevailing levels or a performance level which would incur a greater hardship either on the physician providing the service or the subscriber receiving it."

The MMS Board also acted to defer any modifications in customary charge profiles until January 1, 1971.

The MSMS Council has not given official approval to this program. The Council has requested pertinent statistical data from Blue Shield so that The Council can make its own evaluation. In the meantime, The Council has urged all physicians to use their customary restraint in considering increases in charges for professional services, and to base any changes in charges on their own increased overhead.

Resolution 74 (adopted by the 1969 House of Delegates) which called for a test case on the federal government order on the freeze in the Medicare Fee Schedule was studied by MSMS Legal Counsel. After careful analysis, he reported that although he is willing to proceed there are substantial problems. First, he said, there is the question of whether the government could be sued in this context. Second, it must be ascertained whether the action would have to be brought by an individual physician with respect to an individual fee dispute or whether the matter could be commenced under the declaratory judgment rules. This matter is now under consideration by the Finance Committee which is evaluating the cost aspects of such an undertaking.

Also, The Council received at its July meeting a verbal request from Blue Shield for advice on revamping its corporate structure to provide for a majority of public representation on its Board of Directors. The Kramer bill, which would accomplish this by legislation, passed the House of Representatives and now is being considered by a Senate committee. The UAW and other groups have made similar recommendations to the Michigan Department of Insurance. The Blue Shield proposal is being considered now by the Task Force on MSMS Structure.

1970 MSMS Survey on Professional Liability Insurance

As directed by the 1969 House of Delegates, The Council this spring surveyed MSMS members (excluding those surveyed by the Wayne County Medical Society) about specific problem areas dealing with professional liability insurance.

The survey asked for information about type of practice, limits of liability, premiums, problems encountered in obtaining coverage, claims, suits; and invited suggestions that might reduce the cost of obtaining adequate coverage.

The survey questionnaires were sent out to the approximate 4,800 MSMS members outside of Wayne County. Of this number 2,098 (44%) were completed and returned to MSMS headquarters.

An analysis of the responses to several selected questions revealed the following about those physicians who participated in this survey.

A. Almost all—2,089 (99.6%) are covered by professional liability insurance.

B. The Medical Protective Company insures 1,445 or 70% of those who carried insurance and identified their carrier. Of the remaining replies Aetna accounted for 185, Shelby Mutual accounted for 155; and the 288 were divided among several other companies.

C. 1,836 of the physicians responding to the question about limits of liability carried either $100,000 - $300,000 limits or $200,000 - $600,000 limits.

D. 463 of the physicians reporting had premiums in excess of $1,000. Of these, 19 were in excess of $3,000.

E. 1,061 or 51% of those covered by liability insurance also carried "umbrella type" coverage.

F. 398 answered affirmatively to the question whether they have had either a malpractice claim or suit filed against them. 252 of these were settled out of court. A breakdown of the 173 settlement amounts reported is as follows:

To $500	22	$10,000 - $15,000	12
$500 - $1,000	10	$15,000 - $25,000	4
$1,000 - $5,000	90	$25,000 - Up	8
$5,000 - $10,000	27		

G. 37 trials were reported and of these 29 were won, 4 were lost, and 11 are under appeal.

H. Eight judgments were reported in amounts of: $400, $1,200, $1,500, $4,000, $12,000, $15,000, $31,000 and $206,000.

I. Many suggestions were received to ameliorate the high cost of protection. Most of these dealt with (1) abolishment of the contingency fee, (2) the creation of arbitration panels, and (3) the establishment of an MSMS sponsored insurance program.

Summary Tabulation Sheet

1. Number sent out 4,794 Number returned 2,098
2. Are you covered by liability insurance? Yes 2,089 No 9
3. Name of insurance carrier?

Medical Protective	1,445	Aetna	185
Shelby Mutual	155	Other	288

4. What is your insurance classification?

Class 1: Specializing in Internal Medicine or subspecialties, Neurology, Pediatrics, Pathology, Psychiatry (no shock therapy), Radiology or Dermatology (no X-ray therapy), General Practice (no deliveries, surgery, general anesthesia, spinals, saddle blocks or caudals). 735

Class 2: Specializing in Psychiatry (including shock therapy), General Practice (performing normal deliveries, D & C's and infant circumcisions, or assisting in surgery—no general anesthesia, spinals, saddle blocks or caudals). 243

Class 3: Specializing in Proctology, Ophthalmology. 113

Class 4: Specializing in General Surgery, Urology, Thoracic Surgery, Cardiovascular Surgery, Colon and Rectal Surgery, Otolaryngology (excluding Plastic Surgery), General Practice (performing any surgery in this class—no general anesthesia, spinals, saddle blocks or caudals). 432

Class 5: Specializing in Obstetrics and Gynecology, Anesthesiology, Orthopedic Surgery, Plastic Surgery, Neurological Surgery, Otolaryngology (including Plastic Surgery), General Practice (administering general anesthesia, spinals, saddle blocks or caudals, or performing any surgery in this class). 536

5. What are your present limits of liability?

a. Base coverage:

$5,000 - $15,000	30	$50,000 - $150,000	68
10,000 - 30,000	25	100,000 - 300,000	1,306
25,000 - 75,000	39	200,000 - 600,000	530

Annual Premium Cost?

$ 100 - $ 200	367	1,200 - 1,300	56
200 - 300	149	1,300 - 1,400	73
300 - 400	72	1,400 - 1,500	28
400 - 500	79	1,500 - 1,600	27
500 - 600	46	1,600 - 1,700	33
600 - 700	100	1,700 - 1,800	15
700 - 800	54	1,800 - 1,900	13
800 - 900	116	1,900 - 2,000	13
900 - 1,000	52	2,000 - 2,500	13
1,000 - 1,100	95	2,500 - 3,000	7
1,100 - 1,200	71	3,000 - Up	19

b. Umbrella coverage: Yes 1,061

Amount: $1,000,000	948	$2,000,000	16
$5,000,000	5		

6. Any problems with current carrier? Yes 81 No 1,965

Nature of Problem?
Premium was raised 48
Agent insisted on selling more insurance 12
Getting more coverage 12 Other 9

7. Have you ever had a malpractice suit or claim filed against you? Yes 398 No 1,681

a. Was it settled out of Court? Yes 252 No 69

Amount of settlement?

To $500	22	$10,000 - $15,000	12
$500 - $1,000	10	$15,000 - $25,000	4
$1,000 - $5,000	90	$25,000 - Up	8
$5,000 - $10,000	27		

b. Went to trial? Yes 37

Results:

Won 29 Lost 4 Under Appeal 11

Judgments: 8 Amounts: $400, $1,200, $1,500, $4,000, $12,000, $15,000, $31,000, and $206,000.

8. What can be done about the malpractice insurance cost problem?

Abolishment of the contingency fee	363
Creation of arbitration panels	331
Establishment of a MSMS sponsored insurance program	204

A similar tabulation sheet has been prepared and will be made available to each component medical society covered by the survey.

The Professional Insurance Committee is also meeting with the AMA in order to learn first-hand what progress has been made by the AMA toward finding a national professional insurance carrier.

ADDENDUM A – Part II–1970 Annual Report of The Council

Alexander Grant Company
MSMS Management Study

I. INTRODUCTION

A. Objectives and Delimitations

The following report and exhibits comprise the results of our engagement to assist the Michigan State Medical Society in conducting an organization study of its staff.

In our July 31, 1969 proposal to the Chairman of The Council, we described the needed work as a two-phase program. This report reflects the results of Phase I which, as described in paragraphs four and five of our letter, includes the following:

Consider a program for the development of back-up personnel for key executive vacancies when they occur.

Employee compensation, benefits, and particularly, motivation should be studied to determine if they are adequate to keep present personnel and to attract new personnel.

All key jobs should be redefined and redescribed and the organizational structure revised to make sure of effective use of the available talent and to avoid inefficiencies and duplication.

This describes Phase I of our proposed assignment. It should be conducted without making any changes in your present policies and objectives.

Thus, Phase I includes an evaluation and recommendations of the MSMS staff *in terms of the Society's present purposes* encompassing:

Organization structure

Staffing

Motivation

Compensation and fringes

Management development

Phase I refers to Exhibit A: Present Organization–Michigan State Medical Society, which illustrates the present organization structure of MSMS and our understanding of the structure *above* the MSMS staff. This study encompasses primarily the MSMS staff as shown in Exhibit B *and its interactions with the structure illustrated in Exhibit A.*

Dealing with the hierarchy above of the MSMS staff requires a questioning of the basic policies and objectives of the entire State Society and, therefore, is appropriately a part of Phase II. Phase II will question, and it is hoped, establish more current purposes, objectives and scope of the Society, needed staff support and relative priorities.

B. Methods of Study

In conducting this analysis, we have interviewed extensively all key management members of the MSMS staff and, in fact, nearly all employees of MSMS. We have conducted extensive reviews of related data provided by the staff. We have made several visits at the Society's headquarters and have observed in detail the general working environment and employees of the staff.

We have discussed with the Chairman of The Council and your other consultants some of the problems of the Society and its staff, and we have briefly discussed the problems and organization of medical societies in two other states, primarily to gain some perspective in our desire to understand some of the problems of the MSMS staff.

Unfortunately, our relatively limited budget of $5,000 prevents delving further into some of the identified problems, even though we were tempted to do so. Then, too, one is never able to accumulate all the information available and one can never speak with the many people available who can intelligently discuss the subject and have opinions. Our data accumulation necessarily had to stop at some point where we believed he had *sufficient* evidence to make the *recommendations* needed to accomplish our assigned task.

It should also be noted that Alexander Grant & Company provided the Society with an interim progress report addressed to the Chairman of The Council on February 13, 1970, in which was summarized interim recommendations of this study. The Speaker of the House of Delegates replied on February 20, 1970, following a meeting with the ad hoc task force, to our communication with a letter and instructions for our continued efforts on this study. This correspondence is included in Exhibits P and Q of this report.

C. Report Organization

In general, the following information is arranged to tell first what we have observed in the present MSMS staff: its organization, staffing, organizational environment, compensation, etc.; and then what we believe should be done to make the staff more effective and useful to the Society *as an interim step* that will serve your needs until an in-depth evaluation can be made of the purposes of the Society.

Exhibits are generally sequentially arranged in order of subjects discussed. Documentation of conclusions is provided a priori the exhibits, or with evidence included in this text. We will be pleased to answer any questions following our complete presentation.

D. General Observations

Before discussing the present MSMS staff characteristics, please consider the following concepts which were used in developing our conclusions and recommendations.

Organizations exist because there is a common purpose or purposes to be accomplished which cannot be done by one person.

Employees and management of the organization must understand these purposes and how their individual jobs relate to these purposes to effectively contribute to the organization.

Employees whose jobs and work efforts do not effectively contribute to the organization, regardless of the reasons, inject some form of disturbance into the concentrated and coordinated effort of the group.

Factionalism, personal interests, political ambition, job dissatisfaction, or disinterest, as well as not understanding what one's duties are, nearly always create negative results in accomplishing the organization's goals.

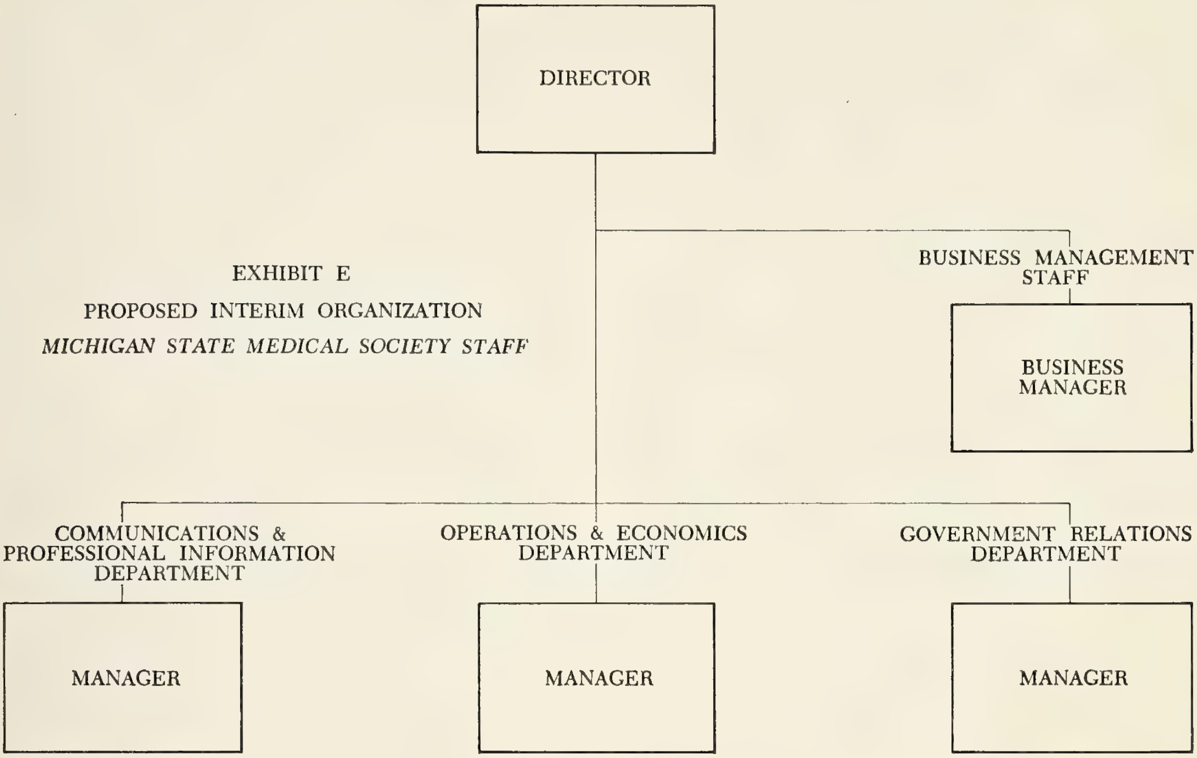

DIRECTOR
BUSINESS MANAGEMENT STAFF
BUSINESS MANAGER
COMMUNICATIONS & PROFESSIONAL INFORMATION DEPARTMENT
MANAGER
OPERATIONS & ECONOMICS DEPARTMENT
MANAGER
GOVERNMENT RELATIONS DEPARTMENT
MANAGER

EXHIBIT E

PROPOSED INTERIM ORGANIZATION

MICHIGAN STATE MEDICAL SOCIETY STAFF

PART III

Matters Referred to The Council by the 1969 House of Delegates

Support of County Health Authority Concept. Resolution 4 directed that MSMS support the concept of a county health authority where appropriate, and outlined the ratio of physician members of such authorities. It also directed that the need for legislation to permit such authorities be studied.

The Council referred the resolution to the Committee on Legal Affairs for consideration. A survey conducted with the help of the Department of Public Health indicated that the introduction of legislation was warranted. The Council approved the recommendation of the Legal Affairs Committee that a bill be introduced in the 1971 Legislature providing that at least one physician (MD or DO) be a member of all county or district boards of health, and such a bill is being prepared for introduction.

Development of MSMS Counseling Service. Substitute Resolution 5 instructed The Council to develop a competent counseling service for itself, MSMS members and component medical societies.

The Council directed that the Committee on Medical Socio-Economics develop such a plan and submit it to the Finance Committee for consideration of the costs involved.

The Medical Socio-Economics Committee, in conjunction with the Public Relations and Governmental Medical Care Programs Committees, is now in the process of improving a detailed plan and cost estimates following suggestions of the Finance Committee.

Physical Examinations for High School Athletes. Resolution 7 urged adoption of a policy by the Michigan High School Athletic Association which would require only one physical examination each at the junior and senior high school levels.

The Council referred this resolution to the Committee on Medical Aspects of Organized Athletics. In discussing this matter with the Michigan High School Athletic Association, the Committee recognized the value of continuing annual examinations and recommended to The Council that no action be taken on the resolution, and that introduction of a countermanding resolution in the 1970 House of Delegates be encouraged. The Council approved the Committee's recommendation.

Medical Service to Needy Areas of Michigan. Resolution 8 directed that an appropriate MSMS committee assist in development of programs encouraging students, interns and residents to serve in needy areas following completion of their training.

The Council referred this resolution to the Committee on Health Problems of the Disadvantaged for appropriate implementation. Subsequently, the committee was disbanded, and its responsibilities were assumed by the Committee on Medical Socio-Economics, which now has this resolution under consideration.

Support of Amalgamation of Medicine and Osteopathy. Resolution 19 reaffirmed the previous position of the House in favor of amalgamation.

The Council referred this resolution to the Committee on Medicine and Osteopathy for information.

Invitations to Medical School Deans to Attend MSMS Council Meetings. Substitute Resolution 22 encouraged medical school faculty members to become active in MSMS affairs, and further directed that representatives of each school continue to be invited to attend meetings of The Council.

The Council has continued during the past year its previous policy of inviting the deans to attend Council meetings. The resolution was also transmitted to the deans for their information.

Orientation of New Members. Resolution 27 directed that component medical societies be responsible for indoctrination of new members, that medical schools be encouraged to include organizational medicine in the curriculum, and that a certificate of membership for new members be designed.

This resolution was transmitted by letter to the component medical societies and they were urged to develop such orientation programs. The Education Liaison Committee brought the requested curriculum changes to the attention of the deans by letter. All replies indicated interest in covering such subjects at the first-year level and expressed willingness to experiment further.

A membership certificate has been developed and is being presented to new members of the Society, beginning in July, 1970.

Communications Between MSMS Members and Their Representatives. Resolution 39 requested The Council to make every effort to expedite the transmission of information of interest to the MSMS delegates.

The Council has expanded as directed the information on Blue Shield and financial matters contained in its minutes.

General Practice in Medical School Curriculum. Resolution 41, which directed that medical schools be encouraged to adequately instruct students in general practice, was referred to the Committee on Education Liaison.

The Committee communicated this request to the three schools and all replied reporting their efforts to increase exposure to the concept of family practice.

Study of Discontinuance of MSMS Relationship with Blue Shield. Substitute Resolution 44 directed that a full study be made of all aspects, favorable and unfavorable, with all the ramifications of the feasibility of discontinuing the MSMS historical relationship with Blue Shield.

The Council referred this matter to the Task Force on MSMS Structure for consideration. (See Report of Task Force, which is being submitted directly to the House of Delegates.)

Appeals from Comprehensive Health Planning Decision. Resolution 47 directed that the Governor be requested to invest the Michigan State Comprehensive Health Planning Advisory Council with the responsibility and authority for adjudicating appeals from decisions of area-wide health planning councils and the Michigan State Comprehensive Health Planning Commission.

The Council referred this resolution to the Committee on Governmental Medical Care Programs for implementation. The Committee transmitted the recommendation to the Governor, and subsequently, the Governor issued an executive order giving the Advisory Committee authority and responsibility for such appeals.

Physical Status Card. Resolution 50 requested that MSMS investigate the possibility of issuing a card to interested individuals after a comprehensive physical examination. The card could be presented in lieu of individual examinations for various activities which are presently required.

The Council referred this resolution to the Committee on Public Health for study and recommendation. The Committee felt there was merit in such a card, but recognized the possibility that insurance companies, individual physicians and others might not accept such a card, and that it might conflict with present laws and public health regulations. The matter was referred to a subcommittee for further investigation.

Authority of the Food and Drug Administration. Resolution 60 on this subject was not approved, but the House directed that an appropriate committee prepare a position paper on "the undue influence of the FDA in the practice of medicine," for the use of the Michigan delegation to the AMA in preparing a resolution for introduction in the AMA House of Delegates.

The introducer of the resolution was requested to prepare such a position paper and it was presented to the Michigan delegation for its information.

Reintroduction of Malpractice Bills. Resolution 63 directed The Council to support certain bills on malpractice and urge their adoption.

The resolution was referred to the Legal Affairs Committee for implementation. However, in spite of MSMS support, these bills died in committee.

Hearings for Professional Liability Insurance Rate Increases. Resolution 71 directed that The Council request the Michigan Insurance Commissioner to hold hearings on any such rate increases, and that an MSMS representative be present at such hearings.

The Council requested MSMS Legal Counsel to comment regarding the desirability of the proposal. Legal Counsel suggested that the purposes of the resolution might be taken up with the Commissioner's office by someone on the staff. He pointed out, however, that no actuarial data was available to be of assistance at such hearings and that no member of the staff had sufficient expertise in this area to make a meaningful appearance.

The Council Chairman was authorized to assign a staff member to contact the Commissioner's office regarding this matter.

Physician Members of Blue Shield Board. Substitute Resolution 85 urged removal of the two three-year term limitation for board members, and directed that MSMS employ adequate staff to serve the physician members of the board. The House also referred to The Council a proposal that MSMS reimburse physician members of the Board for their attendance at board meetings.

In response to the resolution, the Blue Shield Board voted to abolish the term limitation for board members, so this is no longer in effect.

The proposal to furnish staff to serve the physician board members was referred by The Council to the Advisory Committee to the Director, which is considering this matter, along with other matters contained in the Alexander Grant Company management study.

Reimbursement of board members was referred to the MSMS Committee on Utilization and Health Insurance Problems for consideration. Subsequently The Council adopted that Committee's recommendation that The Council recommend to the House of Delegates that physician members of the Board *not* be reimbursed. (See Part II of the Annual Report of The Council for further detail.)

Pamphlet Containing Blue Shield Historical Data. Substitute Resolution 86 directed that a pamphlet containing Blue Shield historical information such as the enabling act, bylaws, consent judgment, etc., be developed and distributed to the House of Delegates.

This reference information is being sent to the Delegates in advance of the 1970 meeting.

MSMS Position re National Health Insurance Programs. Resolution 88 directed The Council to take appropriate action to prepare in advance for any system of national health care.

This matter is being studied by the MSMS Committee on Planning and Priorities which is considering general Society goals for the future.

Michigan Medical Service Report to 1969 House (Part II). The House directed that an in-depth study be made of this special report dealing with MVF, entitled "A Commitment Fulfilled."

The Council referred the report to the Committee on Utilization and Health Insurance Problems for study. Subsequently, the Committee submitted to The Council a factual report, on the contents of the report, and indicated that subsequent events had rendered the report meaningless so that no further action need be taken.

Duplication of Committee Assignments. The Reference Committee on Reports of The Council and Officers urged that The Council revise and combine committee assignments to avoid obvious duplication, where indicated. This recommendation was brought to the Council Chairman and the Speaker.

Possible Elimination of Councilor Conferences. The Reference Committee on Ways and Means recommended that The Council explore the possibility of eliminating Councilor Conferences and leaving such liaison to the individual Councilors and component societies.

The County Societies Committee of The Council studied this matter and subsequently The Council approved its recommendation that the Conferences be held in 1970, but that the agenda include discussion of the worth of the Conferences and the feasibility of discontinuing them.

COMMITTEE REPORTS

16. Annual Summaries of Council Committees

Committee on Alcohol and Drug Dependence

Richard C. Bates, MD, *Chairman*

The Committee held meetings on December 10, 1969 and June 10, 1970.

Routinely, the Committee reviewed legislation having to do with alcohol and drug abuse and made recommendations to the Committee on Legal Affairs and members of the Legislature.

The Committee sponsored a meeting on June 15, to review and discuss State action programs on drug abuse and invited representatives of other groups and organizations concerned with the problem of drug abuse. The meeting was attended by 22 key persons including Doctor Thomas J. Stachnik, Director, Governor's Office of Drug Abuse. The meeting had not been called for the purpose of forming another organization or for making definite recommendations, but as an informal get-together to hear what is going on about the drug problem and perhaps bring about coordination and guidelines.

The Committee is concerned about the "back seat" alcoholism is taking because of the interest being expressed about drug abuse. The Committee discussed whether physicians already skilled in treating alcoholism were the best persons to handle drug dependency or whether this responsibility could be best handled by regular mental health facilities. The Committee concluded that, like alcoholism, drug addiction is a disease and that it is suitable and best that this Committee be concerned with the problems of both.

A meeting was held with a representative of the Michigan Board of Pharmacy to discuss the increase of physicians who are prescribing drugs indiscriminately and the problem of alcoholic and drug addicted physicians. The Committee would like to see some method of control other than the revocation of license and subsequent loss to medicine of a practicing physician. In the near future, the Committee will write guidelines and standards to help physicians in handling problems of narcotic abuse.

The Committee will also propose a statement on drugs that can be accepted as a policy statement of the Michigan State Medical Society.

Liaison was continued with the Michigan Department of Public Health and was established with the Michigan Department of Education.

Committee on Courses on Medical Economics and Ethics

C. Howard Ross, MD, *Chairman*

The Committee offered the following programs, etc., for interested senior medical students at the University of Michigan.

(1) 8/21/69: Dinner for Class Officers, resulting in organization details and subject planning. Mr. Newton Osborne, Sr. Class President, was a most valuable asset in Course Management.

(2) 9/3/69: Lecture, "History of Ethics," by C. Howard Ross, MD.

(3) 9/17/69: Panel, "Race Explosion, The Pill, Abortion Reform, Religious Limitations."
Wm. N. Hubbard, MD
George Morley, MD
Rev. Terry Smith
C. Howard Ross, MD

(4) 10/1/69: Class invited to MSMS, Detroit.

(5) 10/15/69: All classes selected War Moratorium Mass Meeting.

(6) 11/5/69: Presentation: "The Doctor in Court," Hon. Ross W. Campbell, Judge, Circuit Court.

(7) 11/19/69: "The Morality of Specialty Procedures," Charles G. Child, MD.

(8) 12/2/69: All Medical classes were invited to the Medical Forum: "Unbridled Escalation of World Population," Jas. Finkle, Ph.D.

(9) 12/3/69: Presentation and Queries: "Development of a Fee Schedule," C. Howard Ross, MD.

(10) 1/7/70 Dissertation: "Medical Communications." Verbal; Written; Paper Preparation; Records; "The Mike"; Ethical Depletion, when not heard or understood; the Blasphemy of the multiple subject and Fine-Print slide; Life-Time Memories of Medical Philosophies; Referral Techniques; GP, and the Specialist. C. Howard Ross, MD.

(11) 1/21/70: Panel: "Hospital Administration and the Intern." Henry Morris, Assoc. Adm., St. Joseph Mercy Hospital, Edward J. Connors, Director, University Hospital.

(12) 1/27/70: All Medical classes were invited to the Medical Forum: "Perspectives in Federal Health Spending," Edward J. Connors.

(13) 2/4/70: "Professional Medical Management," with Group Discussion: Tim Hogan and Associates. Critic: J. B. Bryan, MD.

(14) 2/18/70: "A Doctor's Philosophy," C. Howard Ross, MD.

(15) 2/24/70: All classes were invited to the Medical Forum: "Community Medicine in the Mississippi Delta," Mary Clifford, MD.

(16) 3/18/70: Panel: "Continuing Medical Education; Keeping Abreast; Following Graduation; The Future of Medical Education." Harry A. Towsley, MD; J. B. Bryan, MD; C. Howard Ross, MD.

(17) 3/31/70: All classes were invited to the Medical Forum: "How to Prevent Suicide by Really Trying." Phillip M. Margolis, MD, Director, Washtenaw County, Mental Health Center.

Kindly take note that the future Senior Medical Classes at the U of M, as organized units, will no longer exist. All students will be individualized as to function assignments. There will be no assemblies, as we have known them in the past, and the MSMS Committee would gather only to face bare walls.

However, the "Medical Forum" is now in its second year in Ann Arbor. It consists of medical faculty, local physicians, ministers and students. Under the direction of Dr. Donald Rucknogel of the Medical Center, the Forum meets each month. Although the seniors will be occupied elsewhere, the Forum will appeal to junior, sophomore, freshmen medical students and also to nurses, student nurses, and members of the faculty.

Therefore, our Committee tip-toes out of the situation, except when Dr. Rucknogel beckons us to enter as individuals.

We, of the Committee, wish to recognize the noble work of the Class President, Newton Osborne, and to express our appreciation in the direction of our very capable panelists and speakers.

Committee on Education Liaison

John R. Pedden, MD, *Chairman*

The Education Liaison Committee, one of four standing committees of The MSMS Council, carried on several activities during the past year. The Committee met two times in 1969-70.

1. *Continuing Study of the Possibilities of Training Physician Assistants in Michigan.* The Committee invited T. F. Zimmerman, PhD, Director of the AMA Department of Health Manpower, and Michigan leaders from the medical schools, State Department of Education, State Board of Registration in Medicine, State Comprehensive Health Planning Commission, Western Michigan University, and chair-

men of several related MSMS committees to a discussion about the physician assistant possibilities. The Committee recommended that "MSMS support the current efforts of Western Michigan University to develop a degree program to train physician assistants, and that the Education Liaison Committee be authorized to offer its guidance and assistance" and this was approved by The Council. WMU has appointed a joint advisory committee of educators and physicians, which is now at work. WMU has filed with the State Department of Education its intention to begin such a new curriculum in 1971. William G. Birch, MD, Kalamazoo, is Chairman of the Committee's subcommittee on the physician assistant.

2. *Relations with the Three Medical Schools:* The deans of the medical schools or their representatives have been regular in attendance and have discussed many matters such as curricula expansion, students, etc., with the Committee. A short progress report was received at the February meeting from MSU Dean Andrew Hunt, Jr., MD, about development of an osteopathic college at MSU. A letter from WSU in April asked MSMS to assist in developing a family practice elective at WSU, and the Committee responded by appointing a special task force committee to confer with WSU.

3. *MSMS-SAMA-MHA Summer Project:* The Committee recommended to The Council, and The Council approved, the co-sponsorship by MSMS with the Michigan Hospital Association, and the SAMA chapters at the three Michigan medical schools whereby sophomore medical students would be placed with Michigan hospitals for a 10-week orientation program on a demonstration basis in 1970. The students will be exposed to a series of clinical and non-clinical aspects of hospital, office, and clinical experience. Plans are to expand the project in 1971. SAMA began this project in Illinois, and Michigan was the second state in the program.

Committee on Emergency and Disaster Medical Services

Charles P. Anderson, MD, *Chairman*

No matters were brought to the attention of the Committee during the past year. Therefore, there were no meetings held.

Committee on Eye Care

Robert T. Blackhurst, MD, *Chairman*

The Committee held meetings on September 17, 1969 and on May 29, 1970.

The Committee serves in an advisory capacity to the Vision Section of the Bureau of Maternal and Child Health, Michigan Department of Public Health, and to the Department of Social Services, Division of Services to the Blind.

Discussions were held on the Medical Eye Care Program of the Division of Services to Crippled Children, Michigan Department of Public Health; school and preschool screening; preschool screening referrals; dyslexia project; new vision standards for Michigan drivers, informational pamphlets for young diabetics; the interpretation of visual fields as recorded on the legal blindness forms; and lens testing for school children.

The Committee notified the MSMS membership regarding Public Act 282 of 1968, which becomes effective as of September 1, 1970 and requires that vision screening of preschool children shall include tests for monocular and binocular visual acuity and for eye muscle balance, using procedures approved by the Director of Public Health, and vision screening tests shall be given by trained persons and the method of their training shall be approved by the Director of Public Health. The Law does not state that the preschool vision test has to be done by an ophthalmologist or optometrist nor does it say that preschool children have to have a complete eye examination—but they do need to have visual acuity and muscle balance tested prior to entering school.

Committee on Group Travel Plans

Alexander Blain, III, MD, *Chairman*

The Committee held one meeting on December 9, 1969.

As of June 22, 1970, 244 reservations were received for the MSMS tour of the Orient immediately following the 1970 MSMS Annual Session. From all indications, it looks like the first group tour for MSMS members will be a great success.

The Committee will meet in the near future to make plans for trips during 1971 and will consider a possible trip to the Eastern Mediterranean and perhaps one to Spain and the Western area of the Mediterranean.

Ad Hoc Committee to Study Health Problems of the Disadvantaged in the Cities

Frank B. Walker, MD, *Chairman*

Since the creation of this Committee, valiant efforts have been made to identify health needs to recommend to MSMS ways to improve health care. Experts communicated their views of listed priorities but the Committee was not able to define the many, complex opinions to isolate one single objective.

The Council approved the Chairman's request to discontinue the Committee and assigned its goals and functions to the Committee on Medical Socio-Economics.

Committee on Hospital Relations

A. Carl Stander, MD, *Chairman*

This Committee met on November 19, 1969, February 25, and May 26, 1970. Joint meetings with representatives of the Michigan Hospital Association related to a Hospital-Doctor efficiency project involved considerable discussion. Minimal funding was provided for joint development of an inventory to survey hospital administrators, trustees and medical staff to stimulate hospitals, obtain project data and to evaluate with the objective for achieving efficiency, economy and quality of hospital care.

HEW Bureau of Health Insurance Letter #138 suggesting medical society evaluation of medical staff activities was reviewed and discussed. The Committee noted a previous attempt in 1966 when a Medical Staff Survey Committee was established and its disbandment because no survey requests were received.

The Committee objected to registered nurses from the Michigan Department of Public Health reviewing staff medical records and medical committee functions in hospitals and recommended that the Director or his physician-apointee should sign these forms.

The Committee reviewed a model form suggested by the Michigan Department of Public Health "Confidential Patient Transfer Record" and suggested improvements.

Liaison with appropriate state and voluntary agencies continues.

Committee on International Health

Hira E. Branch, MD, *Chairman*

During the past year, some members of the International Health Committee have been busy in faraway countries. Alfred B. Swanson, MD, Grand Rapids, is active in Korea and other places in regard to silicone-type prosthesis for joint movements, fingers, elbows, wrist and substitute prosthesis for the various joints of the upper extremities.

Chairman Hira E. Branch, MD, spent November and December, 1969, in Indonesia teaching at the University of Indonesia, in Djkarta, as well as holding clinics and helping educate doctors in orthopedic surgery. This is a three-year training program for residents, held in conjunction with the Australian Orthopedic Society. The United States MDs alternate with the Australian doctors during this period, and the program is working out quite satisfactorily.

Doctor Nevit A. Ergin, of Flint, has been active in Trinidad and other countries doing plastic surgery during the last year.

The Committee has had surgeons, general surgeons, chest physicians, cardiologists, plastic surgeons, anesthesiologists, inquire where they could work on a voluntary basis. These have been handled with dispatch.

An attempt has been made to see if some of the foreign doctors training in this country could be influenced to spend one or two years in some of the smaller Michigan cities and towns where doctors are not available. The Committee will discuss this further at a later date.

Liaison Committee with Michigan Chapter of Health Insurance Council

Brock E. Brush, MD, *Chairman*

This Committee did not formally meet.

Representatives of HIC met informally with MSMS staff on March 24, 1970 to keep the channels of communication open and to discuss HIC activities with AMA or any problems of mutual concern in Michigan. The purpose and function of MSMS Regional Medical Advisory Committees and the mechanisms necessary to arbitrate complaints were discussed.

Copies of relevant memoranda were distributed.

A meeting will be held when the Regional Medical Advisory Committees have been established.

Liaison Committee with Michigan State Pharmaceutical Association

Robert E. Rowe, MD, *Chairman*

The Committee met on May 20, 1970.

An MSMS House of Delegates Resolution "Pharmacists Review of Hospital Orders" was reviewed to determine the intent and effectiveness of Rule 16 (c) of the Michigan Board of Pharmacy if it needed to be rescinded or modified. Authorization was requested to poll hospital medical staffs to determine the effectiveness of this rule and to request suggestions for correcting.

The Committee adopted a new Code of Understanding and requested that Council recommend approval by the 1970 MSMS House of Delegates.

Concern was expressed by MSPA of overprescribing by physicians and the Committee requested authorization to insert an article in *Michigan Medicine*.

Physicians' offices are a prime target for burglarizing stimulants, depressants and narcotics so authorization was requested to include an article in *Michigan Medicine* to suggest additional precautions and maintenance of minimum drug supplies for office use.

Other matters included: Methadone, as a maintenance program, and the Federal Harrison Narcotic Law were discussed relative to the use of this drug by practicing physicians.

Liaison continues at all appropriate levels.

Liaison Committee with Podiatry

William H. Blodgett, MD, *Chairman*

Members of the Committee participated in a meeting with the Michigan Podiatry Association, Michigan Hospital Association and the Greater Detroit Area Hospital Council in Detroit. The purpose of the meeting was to examine the role of the podiatrist in the general hospital of the future. The Committee continues to investigate areas of mutual interest to podiatrists and physicians in order to facilitate the delivery of quality health care.

Liaison Committee with Residents, Interns, Senior Medical Students

This Committee has not met during 1969-70. The last major project of the Committee was to sponsor a workshop at the 1968 MSMS Annual Session in Detroit when the Committee invited interested interns and residents to attend an "Office Management Seminar."

No specific projects were assigned to this Committee during the past year. The Committee was saddened by the death of its Chairman, Norman D. Henderson, MD, of Lansing, on December 10, 1969.

Some of the concerns that MSMS has for residents and interns have been considered during the past year by the MSMS Committee on Postgraduate Medical Education and by the MSMS Education Liaison Committee. There are some overlapping areas of possible study and involvement.

Liaison Committee with State Bar of Michigan

O. J. Johnson, MD, *Chairman*

The Committee met on June 10, 1970.

The Committee was charged in Resolution 20 of the 1968 MSMS House of Delegates to make a recommendation concerning the "legality and advisability of establishment by law of a method of binding arbitration voluntarily agreed to by both parties in malpractice suits."

A Michigan Statute "Uniform Arbitration Act" and a Resolution adopted by the State Bar urging legislation to include voluntary arbitration in insurance policies were reviewed. The Committee felt that it could not support similar legislation until experience data from other states with similar legislation could be thoroughly studied. This matter was referred to the Committee on Professional Insurance Plans because it did not come under the purview of this Committee. MSMS and the State Bar agreed in 1969 to revise the section "Compensation for Services of Physicians" in the Statement of Principles for Lawyers and Physicians adopted 1957. The revision defines the attorney's responsibility for reimbursing physicians when the physician contributed to the preparation of a court case. The Committee requested The Council to authorize printing of the new Statement, as amended, in *Michigan Medicine*.

Liaison with Board of Registration in Medicine

O. J. Johnson, MD, *Chairman*

This Committee did not meet because no matters were referred.

The Committee continues to check the status of SB 1440 that would increase the membership to 15 of whom 5 would be lay members. This bill is presently dormant.

Liaison Committee with State Executive Office

Kenneth H. Johnson, MD, *Chairman*

During the past year this Committee has maintained constant contact with the Executive Office of the Governor, communicating on health matters in the areas of legislation, appointments, executive orders and administration.

The relationship which has been established with the chief executive and his advisory staff continues to be open and gratifying.

Committee on Medical Aspects of Organized Athletics

Gerald A. O'Connor, MD, *Chairman*

The major activity of the Committee, along with the study of several matters, was the sponsorship of the Fifth Annual Michigan Conference on the Medical Aspects of High School Sports, April 30, 1970 at the University of Michigan Towsley Center. The attendance of more than 200 team physicians, coaches, trainers and school officials was well above the 1969 conference. The University of Michigan Medical School Department of Postgraduate Medicine co-sponsored the conference. The day-long program featured addresses and demonstrations by Michigan authorities in athletic medicine, and by several out-of-state experts.

The Committee met twice during the year.

The Committee was asked by The MSMS Council to study Resolution 7 adopted by the 1969 House of Delegates. The Committee met twice with officials of the Michigan High School Athletic Association and advised The Council to delay implementation of the resolution until the matter could be reconsidered by the 1970 House of Delegates. Committee members will introduce a new resolution countermanding Resolution #7 which advocated only one physical examination at the junior-high-level and one at the senior-high-level.

Among other matters, the Committee studied possible ways to upgrade medical care given high school athletes and further ways to improve the training given to school trainers.

Committee on Medicine and Religion

Winslow G. Fox, MD, *Chairman*

The Medicine and Religion Committee held its annual workshop and meeting at the Wayne County Medical Society building, in Detroit, on April 1, 1970.

Thirty-eight doctors and clergymen from many areas in Michigan were welcomed at the workshop and introduced by Chairman Winslow G. Fox, MD.

Reverend Paul McCleave, Director of the AMA Department of Medicine and Religion, made a presentation on national purpose, stating that the Department was established in 1961 and now has state committees in all fifty states with over 40% of county medical societies participating. He elaborated on the program generally with emphasis on M and R doctors making contact with the seminaries in their areas.

Reports on county M and R activity were given by the chairmen of many of the thirty-eight county committees present. Chairman Fox cited major area meetings held in Kent County, Oakland County, and Marquette County.

The evening meeting, following a reception and dinner, was chaired by George F. Porretta, MD, and presented a panel including Reverend Paul B. McCleave, Moderator, Monsignor Francis Canfield, Ralph R. Cooper, MD, Winslow G. Fox, MD, Reverend Dwight S. Large, John W. Moses, MD, and Rabbi Jacob E. Sagel.

The speaker of the evening was Reverend Granger E. Westberg, Wittenberg University, speaking on the topic, "Good Grief . . . A Constructive Approach to the Problem of Loss."

Committee on Nursing

J. W. Moses, MD, *Chairman*

There were no matters referred to the Committee and, consequently, no meeting was held.

Committee on Medical Quackery

Joseph N. Schaeffer, MD, *Chairman*

The first project of this Committee was to introduce a resolution in the Michigan House of Representatives calling for a Committee to study chiropractic in this state. The Committee met with members of the Public Health Committee in the House, but the resolution has not received action during this session. Additional avenues will be explored in the legislative area in the upcoming year.

The Committee met in Detroit to review recent publications regarding chiropractic and discussed plans for an action program to limit these practitioners. The Committee plans to work with the press in various newspapers in the metropolitan areas and in the smaller communities around the state to get some factual articles on chiropractic published as a public information service.

Committee on Relative Value Study

Alexander Blain, III, MD, *Chairman*

The Committee had no matters referred to it and did not meet during the past year because The Council had decided to defer the reprinting of the Michigan RVS. The 1969 MSMS House of Delegates authorized The Council to reprint the Michigan RVS, but after considerable study at several Council meetings and at Council reference committee sessions it was agreed to wait until the AMA published its Second Edition of the Current Procedural Terminology. The AMA during the early spring published the new edition, with five digit number coding. It was studied by The Council and on 7/20/70, The Council endorsed the AMA CPT coding and description of physician services as the best available. AMA officials have reported to MSMS that insurance carriers and governmental agencies are considering the new CPT as the possible standard system for reporting medical services.

Committee on Rehabilitation

Lionel L. Davis, MD, *Chairman*

The Committee held meetings on January 29, 1970 and on May 7, 1970.

The Committee met with Andrew D. Hunt, Jr., MD, Chairman, State Planning Committee and Hermann A. Ziel, Jr., MD, Chief, Bureau of Medical Care Administration, Michigan Department of Public Health, to discuss medical review and nursing evaluation of State patients in nursing care facilities and homes for the aged. Subsequently, the Committee contacted all component medical societies and urged them to arrange for a meeting at which a socio-economic-political point of view of rehabilitation care and programs could be discussed. The Committee desires that: 1. The present status of rehabilitative medicine, in both short and long term units, be more profiled; 2. The question of progressive care development be discussed as to its proper placement and nature and future health progress; and, 3. That special problems in regard to long term care be discussed and suggestions made.

A subcommittee is developing a statement on optimum medical care and this will be finalized by the Committee in the near future.

The members are concerned that decisions and policies regarding patients in extended care facilities are made by other than medical persons and that this can be constituted as the practice of medicine; that in most cases, over-utilization is determined by a nurse; that patients in extended care facilities need adequate medical direction by a knowledgeable physician; that physical therapy should be a part of the medical treatment; and that ways to eliminate abuses in physical therapy should be brought about. The Committee feels the Michigan State Medical Society could well become involved in this by putting a stop to all attempted audits of medical matters by lay persons. The Committee plans to hold a workshop for the medical directors of the 42 extended care facilities in Michigan to discuss the problems of ancillary charges by third party pay groups.

Committee on Utilization Review & Health Insurance Problems

Robert C. Prophater, MD, *Chairman*

The Committee was created by The Council in March, 1970 and is charged with several functions: (1) It will serve as an appeal mechanism for the Regional Medical Advisory Committees and thus serve as the MSMS Utilization Committee, (2) It will be concerned with frequency of use patterns, based upon data supplied by Michigan Medical Service, and (3) It will discuss with the officials of Michigan Medical Service serious questions and reports that require more intense study than is possible during monthly Blue Shield reports to The Council.

The Committee held meetings on April 21, 1970 and July 6, 1970.

Our major objective is to assist Michigan Blue Shield in resolving disagreements over physicians' charges and allegations of improper performance by physicians in matters of utilization. The Council has informed Blue Shield that these matters should be documented and processed through the MSMS Peer Review Program in which we serve an important role.

Also, we will continue our meetings with Blue Shield and other insurance carriers to try and resolve the many problems involved in the rising costs of medical care.

17. Annual Summaries of Standing Committees

Advisory Committee to Michigan State Medical Assistants Society

Glenn E. Millard, MD, *Chairman*

The Advisory Committee met for its annual session on April 24, 1970, and a quorum was present. The State Medical Assistants Society is now twenty years old officially, and actually is ten years older than that. The last convention was held April 24 and 25, 1970, at the Pontchartrain Hotel in Detroit. In the opinion of the Advisory Committee, this convention was carried off in a professional and excellent manner.

The Constitution and Bylaws of the Michigan State Medical Assistants Society has been reviewed and revised. They have expanded their Education Committee and functions, and following this revision and extension of their activities, an improvement in their organization should occur.

A prominent Michigan medical assistant was part of a panel on health careers held April 25, 1970 in Detroit. An excellent summary of the field of the Medical Assistant was presented.

A meeting is soon to be held with at least one Junior College to upgrade the educational program to conform with the new approved minimum essentials for a medical assistants' educational program, as approved by the Council of Education of AMA.

A letter from the Advisory Board was directed to Blue Shield criticizing the method of education which Blue Shield now holds in their meeting with medical assistants. A copy has been sent to the Speaker of the House. We are hopeful that Blue Shield can be persuaded to cease propagandizing the medical assistants individually and in groups in matters that pertain to the relationship between the Medical Society and Blue Shield and are not properly a consideration for the medical assistant.

The Advisory Committee realizes the cost to the Michigan State Medical Society in time and money and in providing the services of a staff co-ordinator, and therefore, formally acknowledges its thanks for these services rendered to the Michigan State Medical Assistants Society.

Advisory Committee to the Woman's Auxiliary

Milton R. Weed, MD, *Chairman*

The Committee wishes to draw the attention of Council to some of the fine and continuing projects which our medical wives have again undertaken.

The third state wide Legislative Day was held in Lansing this spring with a morning of legislative education for the wives, culminated by a joint luncheon for wives and their legislators. The personal contacts and discussions on an individual basis which resulted, seem to make this joint luncheon an aspect for consideration again in future Legislative Days. The Committee wishes to thank the Michigan State Medical Society for its financial support of a large portion of this project.

The Woman's Auxiliary should again be congratulated for their fine contributions to AMA-ERF, and for their support on the local level of many health career projects.

The Auxiliary also makes large contributions both in time and financial aid to such areas as: Mental Health, International Health, Safety Preparedness, and Community Health.

Auxiliary membership by a larger number of the wives of members to the Michigan State Medical Society will be necessary in the future in order to promote these and many other worthy projects on the high standards of the past.

Committee on Cancer

Max E. Dodds, MD, *Chairman*

The Committee held one meeting on November 12, 1969 and had to cancel its June meeting but completed the agenda business via mail and report to The Council.

The work of its Subcommittee on the Study of Cancer Registries was reviewed by the Committee and approval was given to the Subcommittee to continue its study of the development of cancer registries, with appropriate follow up, in all hospitals throughout the state.

Report was submitted by the Subcommittee on the Status of Self-Administered Pap Tests and the Committee was authorized to continue its study and to appoint additional representatives to the Subcommittee. Three possible solutions have been suggested:

(1) An intensive educational effort involving patients, doctors, and hospitals;

(2) Encourage or make mandatory that a Pap smear be made during pregnancy;

(3) That Pap tests be performed on all hospital in-patients. The Subcommittee will study the volume of Pap smears being done in the State; method or technique to be sure that all hospital patients get a Pap smear; and a positive program that can be implemented.

The Council approved the endorsement by the Committee of the "Six Point Cancer Detection Examination" as proposed by the American Cancer Society, Michigan Division, as a minimal examination of non-symptomatic patients.

The Committee's representatives met with the Michigan Cancer Coordinating Committee and has been kept up-to-date on cancer activities throughout the State and is involved in in-hospital cancer matters by offering speakers to county and district societies and to Michigan hospital staffs, the Michigan State Medical Society, the Michigan Association of Osteopathic Physicians and Surgeons, and the Michigan Dental Association.

The Committee is studying the possibility of a Michigan oral detection program.

Committee on Cardiac Disease Control

Michael C. Kozonis, MD, *Chairman*

The Committee met on April 8, 1970.

The Committee heard report on the Ann Arbor Coronary Drug Project and looks forward to receiving the published statistics.

The Michigan Heart Association's Critique on Nutrition Survey was reviewed by the Committee and recommendation was made that this valuable and good information be put to good use by the Nutrition Committee.

The Committee recommended to The Council that it endorse the ECG-IQ Physician Education Program to the Michigan Heart Association as being a desirable and a worthwhile educational venture and that it furnish the Association with addressing services for all members of the 14 mailings of the proposed flyer (ECG Quizzes) during a 28 week period, with the MHA paying postage and the MSMS addressing the folders, and that the Michigan Heart Association do an evaluation of the Program about the tenth month. Because of the expenditure of funds, this recommendation of the Committee has been referred to the Finance Committee.

A subcommittee will be appointed to develop a policy statement on smoking and health with specifics on implementation and publicity campaign. The report of the subcommittee will be presented to The Council for further consideration.

The Committee met with Mr. Oliver H. Wendt of the Michigan Heart Association and heard report on the Coronary Care Unit Training Program.

Donald C. Overy, MD, Chairman, Professional Advisory Council on Heart Disease, Michigan Association for Regional Medical Programs, met with the Committee and discussed its Cardiac Disease Program.

Committee on Child Welfare

John M. Dorsey, Jr., MD, *Chairman*

The Committee held meetings on October 8, 1969 and on June 17, 1970.

The Committee adopted a statement concerning what constitutes ophthalmological and optometric care that can be used by physicians as a guideline and publicized this information to all members.

Discussions were held on the subject of abortions, sterilizations, use of the Rubella vaccine, the 1970 White House Conference, school health medical supervision, child care institutions and child placing agencies, comprehensive health planning, acute medical and surgical care to minors, dissemination of legislative information, drug abuse, delinquency, allied health workers, education of pregnant girls, Medicaid abuse, and the research and social aspects of Medicine.

The Committee is recommending to the Committee on Legal Affairs that it provide for new enabling legislation to include the availability of acute medical and surgical care to minors, age 16 or under without parental consent; that action be taken in support of state legislation in manufacturing and trade of amphetamines and possibly barbiturates by pharmaceutical companies in the United States and stronger state regulations in prescribing of amphetamines; and that the Governor be requested to reappoint or reactivate the Michigan Youth Commission or that a similar group be developed without further delay.

The Committee referred to the Committee on Planning and Priorities the recommendation that a Committee on Research and Development be established to be concerned with the many biochemical and social research problems facing organized medicine today.

The matter of the education of allied health workers in Michigan universities and to allow for a limited medical practice by such allied health workers, has been referred to the Education Liaison Committee.

The Committee is making a study of the best way to disseminate legislative information of concern to physicians who care for children; a simplified standard form for reporting physical examinations; and, an evaluation of Medicare from the doctor's viewpoint and from the patient's standpoint.

Committee on Governmental Medical Care Programs

Robert E. Rice, MD, *Chairman*

The Committee met on January 28, 1970. Two additional meetings were held with the MSMS Committees on Socio-Economics and Public Relations to study medical costs and trends in relation to Substitute Resolution #5 of the 1969 MSMS House of Delegates.

Resolution #78 of the 1969 MSMS House of Delegates directed that there be "improved payment for physicians' services on the usual, customary and reasonable fee concept" under the Veterans Administration Hometown Care Program. An operational report was made by V.A. officials detailing the payment schedule used as compared to other federally-funded programs.

The Committee and staff initiated monthly articles in *Michigan Medicine* detailing pertinent changes, views and activities about all Federal medical programs as they affect the profession. Widespread approval of this activity has been received.

Considerable study has been devoted to Comprehensive Health Planning with particular concentration on philosophies, activities and recommendations. The Governor issued Executive Order 1970-1 which retained this program within his Office, defined the responsibilities of the Commission and Advisory Council and created a new Office. This Directive included an appeal mechanism which permits any aggrieved public or private agency to a hearing on adverse decisions that MSMS had previously recommended. CHP proposed franchising legislation that would grant approval authority to area-wide agencies on proposed health care facility construction and expansion. This matter was reviewed as it relates to Council action in December, 1965 and specific objections were referred to the Legal Affairs Committee.

The Committee concurred in objections by the Michigan Nursing Home Association to proposed administrative rules by the Michigan Department of Public Health for certifying and licensing nursing homes.

An Attorney General's opinion that chiropractors are "physicians" and are eligible for reimbursement when treating Title XIX (Medicaid) patients and correspondence between The Council, Governor and Social Services were reviewed. The Council Chairman wrote a letter to HEW and Social Services expressing MSMS objection to including chiropractors under Medicare and Medicaid.

The Wayne County Medical Society submitted a request "seeking MSMS assistance in surveying the medical needs, facilities and services now available in the Inner City of Detroit." The Committee reviewed all statistical and analytical data assembled by staff which was subsequently transmitted to WCMS for information.

The Committee devoted study or acted on: The method used by Blue Shield of computing physicians' profiles; actions taken at the 1969 AMA House of Delegates and initial recommendations of the HEW Task Force on Medicaid and Related Programs; national health insurance; the continued necessity of physicians' involvement in comprehensive health planning; the relationship between Hill-Burton and local/State CHP Councils; objected to unsubstantiated and biased allegations by the news media concerning physicians earning $25,000 or more a year treating Medicare and Medicaid patients; direct billing of Medicaid on a prn basis; per-case participation of Blue Shield patients and opposed recertification.

Additionally, staff liaison with all Federal/State Agencies and dissemination of informational data about OEO, CHAMPUS, neighborhood health clinics, and MARMP has accelerated for response and assistance to individual practitioners and MSMS.

Committee on Highway Injury

Paul W. Gikas, MD, *Chairman*

The Committee met on January 14, 1970.

Matters considered and discussed were: The Michigan Department of Public Health Hospital and Ambulance Service Survey; grants to counties providing or contracting for ambulance services; the Michigan Department of State Medical Evaluation and Advisory Group; regulations for licensing drivers with convulsive disorders; snowmobiles and the need for more intensive efforts to advise the Legislature and the Michigan Department of Public Health of mutual concerns.

The Chairman, three members and staff attended an initial meeting to establish Michigan Emergency Services Health Council (MESH) which would combine government and voluntary agencies into a single advisory body on the subject of emergency medical services.

Efforts are continuing by the Committee to upgrade and improve ambulances, equipment and training standards and the Chairman appointed a sub-committee with sole responsibility for emergency medical services.

Other matters included: Analysis of legislation related to standards for drivers with epileptic disorders; Resolution 30 of the 1969 MSMS House of Delegates for improvement of school bus safety requirements by the Legislature; a response to a request from the Michigan Department of Education about first-aid requirements for school buses; and a *Michigan Medicine* article detailing a unique system of providing emergency medical care in Grand Rapids.

Staff regularly attended State Safety Commission and other appropriate meetings.

Committee on Hospital Privileges

Francis P. Rhoades, MD, *Chairman*

The function of this Committee is to ascertain the extent to which all ethical, licensed physicians in Michigan have appropriate hospital staff privileges. Accordingly, the Committee developed, under the direction of The Council, a Hospital Privileges Questionnaire, consisting of eight questions designed to reveal the type of hospital privileges available to physicians.

Since the original impetus for the study came from physicians in the metropolitan area, the questionnaire was initially mailed to all MSMS members in Wayne County.

Responses from the survey indicate that although the majority of physicians are satisfied with their hospital privileges, there is a sufficient number who are not. It appears the greatest defect is in the absence of training programs for additional privileges in metropolitan hospitals.

The Committee feels that in order to formulate complete recommendations to The Council, the questionnaires should be mailed to the outstate physicians as well, in order to have a complete picture of the state. The Committee will so recommend to The Council.

The Committee also seeks to fulfill its additional functions to aid physicians in obtaining appropriate staff privileges in at least one full-facility community hospital in the area in which they practice.

Committee on Legal Affairs

Otto K. Engelke, MD, *Chairman*

Activities of the Legal Affairs Committee during the past year have revolved around reviewing legislative proposals relating to health, making the appropriate response to those proposals of primary interest to medicine, implementing legislative directives of the 1969 House of Delegates and overseeing the new "volunteer lobbying program."

The most significant legislative success of this year came in mid-summer with the passage of House Bill 4059, an amendment to the Basic Science Law. Effective August 2, graduates of accredited medical schools in the United States no longer are subject to the basic science examination in Michigan. The requirements still apply to all graduates of foreign medical schools. The Committee had recommended that, while still short of outright repeal, the amendment would vastly improve the recruiting of out-of-state physicians for Michigan. The basic science amendment represents the fruition of repeating labors on the part of many physicians who have worked on behalf of basic science change.

Other items which successfully moved through the legislative process with MSMS support include a bill adding rubella to the list of immunizations for which an accounting must be made for all entering school children, a bill to permit the temporary retention of an abused child, and another to revamp the Mental Health Advisory Council.

Generally, health measures were not top priority items for the 1970 Legislature, and many MSMS sponsored bills failed to receive attention. Bills that fell short of passage by both houses include: confidentiality of medical records, public health officers liability, amendment to minor's consent of treatment for venereal disease, state public health director qualifications, county public hospital boards of trustees, and amendment to the ambulance laws.

The items above, plus any which were introduced in the 1968 session such as single medical practice and malpractice bills, will not be eligible for action after the end of this session. The 1971-72 Legislature will start in January with a clean slate, requiring that all bills of interest to medicine be reintroduced. This Committee plans to begin drafting legislative proposals for the 1971 session in the near future. The Committee reviewed a great many legislative proposals during the past year and discussed their relative effect on medicine. Bills which were judged to be of interest to the medical profession were supported via written communication to appropriate legislative committees and individuals, or by direct testimony at committee hearings. The Committee wishes to take his opportunity to express its appreciation to the many physicians who offered their time and expertise to speak to a particular topic or bill under consideration by the Legislature.

Upon recommendation of the Committee last year, the 1969 House of Delegates authorized the "volunteer lobbying program" to begin concurrent with the 1970 legislative session. Nineteen physicians volunteered to spend one week each representing the Society in the State Capitol. During their week they spoke to numerous legislators, vocalizing the position of MSMS on health related bills.

In chronological order, volunteer lobbyists for 1970 were: Robert Huebner, MD, Hastings; Louis R. Zako, MD, Allen Park; Charles L. Oppy, MD, Roscommon; Raymond L. Hockstad, MD, Escanaba; F. P. Rhoades, MD, Detroit; Jack M. Stack, MD, Alma; James D. Fryfogle, MD, Southfield; Perry W. Greene, Jr., MD, Grand Rapids; Oscar D. Stryker, MD, Mount Clemens; Brooker L. Masters, MD, Fremont; William A. DeYoung, MD, Saginaw; Frederick S. Gillett, MD, Grand Rapids; Roger F. McNeill, MD, Grosse Pte. Farms; Thomas C. Payne, MD, Lansing; Frederick W. Bryant, MD, Birmingham; Mahlon S. Sharp, MD, Lansing; Keith M. Holmes, MD, Pontiac; Edwin M. Knights, Jr., MD, Southfield; and John W. Grigg, MD, Bay City.

The Committee would like to express its most sincere gratitude and appreciation to those physicians who participated in the first year of the program. Details of the program are included in the report to the House as part of The Council's Annual Report (Legislative Affairs).

The Committee noted, with regret, the resignation of MSMS legislative counsel, M. A. Riley, in May of this year. Mr. Riley had assisted the Committee and MSMS for 10 years and his capable service will be missed. In July the Committee also noted the resignation of Otto K. Engelke, MD, as Chairman of the Committee.

Committee on Maternal and Perinatal Health

James E. Harryman, MD, *Chairman*

The Committee held meetings on September 25, 1969, January 8, 1970, March 25, 1970, and on May 21-22, 1970, as well as several meetings of its subcommittees and executive committee.

The Committee received the first preliminary study of Perinatal Mortality in Detroit and received the approval of The Council to proceed as indicated in the report.

The Committee plans a summit conference of all those individual agencies who are currently working in this same area of concern with the hope that this conference and the exchange of ideas that would occur there will crystallize the thoughts of many into logical working plans to solve this urgent problem.

A resolution providing for funds for prenatal care under the Michigan Bureau of Social Services has been approved by The Council and turned over to the Michigan State Medical Society Committee on Governmental Care Programs for proper follow through. The resolution is that prenatal care should be included in the Title XIX benefits for categorically and medically indigent mothers in the State of Michigan, whether rendered by private physician or properly organized obstetrical clinics according to the patient's choice.

Another continuing project of the Committee is the Michigan Placental Registry at the Michigan State University. The Committee has requested the approval and cooperation of the Michigan Society of Pathologists and information will be sent to all hospital pathologists in Michigan.

The Subcommittee on Maternal Mortality Review has reported a very satisfactory reduction of maternal deaths since 1969. The 49 deaths in Michigan last year have all been reviewed by the Committee. (Rate should be calculated: 1.9/10,000 live births).

The Committee sponsored another successful Michigan Conference on Maternal and Child Health with the Clara Elizabeth Fund of Flint and request has been made to the Fund to continue its financial support of this worthwhile postgraduate meeting which has grown from an attendance of 250 to a standing-room-only crowd of over 500.

A strong recommendation has been made to the State Department of Education to adopt some type of sex education guidelines to be of help to teachers, communities and others interested in setting up sex education programs.

A desk reference card on "Non-Sensitized RH Negative" was written and distributed and the Committee is working on three additional cards: "Low Birth Weight of Infants," "Suggested Standards on Prenatal Care," and "Fetal Distress."

A representative from the Michigan Association of Osteopathic Physicians and Surgeons has been appointed to serve as Special Representative to the Committee.

Other interests and projects of the Committee are: Maternal tissue registry, rubella vaccine, illegitimacy and the news media, statement on sex education, Medicaid payments to private practitioners, Michigan abortion laws and abortions in institutional settings, voluntary sterilization, hospital obstetrical departments and beds, Expectant Parents Teacher Institute, family planning programs including hospital responsibilities, computer review of perinatal statistics, vasectomy and tubal ligation study, and the obtaining of information as indicated on the Michigan birth certificates.

Committee on Medical Socio-Economics

Dale L. Kessler, MD, *Chairman*

The Committee received several major assignments from The MSMS Council and met April 29, May 13, and June 17. The first session developed a working plan for the next two meetings, which involved members of the Committee on Public Relations and the Committee on Governmental Medical Care Programs. This new approach to bring together MSMS committees with a common concern was rated as very successful by the participants.

The Committee offered the recommendation, which was later approved by The Council, that the ad hoc Committee to Study Health Problems of the Disadvantaged in the Cities be discontinued and its goals and functions be assigned to the Committee on Medical Socio-Economics. The Chairman of the ad hoc committee was made a member of the Socio-Economics Committee, as was the Chairman of the Committee on Rural Medical Services to increase the rural point of view on issues and solutions.

The Council referred to the Committee Substitute Resolution 5 from the 1969 House of Delegates "for study as to the possible costs of this service." The Substitute Resolution had instructed The Council "to develop a competent counseling service for itself, the members of MSMS, and the component societies of MSMS." The Resolution had also proposed that "this service shall be available for consultation to negotiators of contracts for medical services, including consumers and other groups in the negotiating of contracts or other arrangements for the purveying of medical services."

This matter was studied in detail at the two combined workshops, where the members "emphasized the need for an adequate budget to engage the necessary staff and to offer the strongest possible services." Committee members discussed the matter with members of their component societies and reported general support for this proposed project and the possible need for extra dues to fund it. The Council Finance Committee and the Socio-Economics Committee is trying to develop a detailed budget for the counseling and negotiating service and to estimate the amount of a possible dues increase needed to cover the estimated costs. The Council will report further on this matter to the House of Delegates in September.

On March 24, Council Chairman Taylor requested the Committee to evaluate the possibilities of preparing an MSMS request to the federal government for funding for a multiphasic screening mobile unit and demonstration, pilot program to serve the inner city. Information was obtained about the mobile units operated by the Michigan Department of Civil Service as part of its group insurance health maintenance program, from the State of Wisconsin Department of Health and Social Services about its mobile units which had only limited experiences in the Milwaukee inner core, and from the Detroit United Health Organization which annually conducts Health-O-Ramas to provide some limited tests. It was agreed that a pilot project first must be undertaken to study an adequate sample section of the inner city to determine what medical needs actually exist. The Committee sought approval from The Council, and it was granted in July, to call together representatives of MSMS, the Wayne County Medical Society, appropriate agencies, organizations and institutions to form a special task force to consider a multiphasic health screening pilot project in a small portion of the Detroit inner city in order to obtain data about medical needs.

The Committee also studied the "foundation" approach used in some sections of the nation to provide medical services to people in the area; and the Committee spent part of one workshop discussing the costs of medical practice and the costs of medical care with an officer of Professional Management.

Committee on Mental Health

Benjamin Jeffries, MD, *Chairman*

This Committee met on November 7, 1969, January 23, 1970, and April 24, 1970. Appropriate State Legislators were hosted at a dinner-meeting on February 23, 1970 for discussions.

The MSMS position on sensitivity training is still receiving wide-spread publicity. Liaison with appropriate AMA committees has broadened.

The Committee discussed: problems of the Wayne County Community Health Services Board; the Blue Shield, MVF, and drug programs, National Health Insurance, Community Mental Health Services under PA 54; alcohol and drug dependence and physicians' workshops. A number of legislative bills were analyzed, positions taken and referred to the MSMS Legal Affairs Committee.

Other matters included: a recommendation for small drug abuse centers; the inclusion of psychiatric services in any national health insurance program; AID bulletin; a Report of the AMA Sixteenth Annual Conference; commitments to state hospitals; mental health services in comprehensive health planning; and increased liaison with the Executive Office, federal and state agencies.

The Chairman testified at a public hearing opposing a change in the qualifications of PA 54 Directors, and the Chairman and staff have regularly attended meetings of the Advisory Council to the Director of Mental Health.

Committee on Michigan Medical History

Irving F. Burton, MD, *Chairman*

During the MSMS Centennial observance in 1965, interest in Michigan medical history was at its highest point in many years. A series of articles about MSMS appeared each month in *Michigan Medicine*, written by William J. Stapleton, Jr., MD, of Detroit, the MSMS Historian. An official Michigan Historical Society plaque was erected during the Centennial session in Detroit marking the place where the first meeting of the Society was held in 1865 on Woodward between Congress and Larned. The Centennial year had other historical overtones and The MSMS Council appointed its first Committee on Michigan Medical History that fall. In the five year period, the Committee has met once to discuss possible projects.

The current Chairman of the Committee, Irving F. Burton, MD, because of his personal interest in various aspects of Michigan medical history wrote an extensive article about the serious cholera epidemic in Michigan in 1832-34 and it appeared in *Michigan Medicine*, on page 1013 in 1969. Other articles have appeared from time to time in the MSMS journal.

Several interested MSMS members, and the current Committee Chairman, question if a standing committee is needed to develop journal articles, etc. The interest in Michigan medical history tends to be a personal matter with some physicians; and a special task force committee can be appointed as logical arm of the MSMS Committee on Public Relations for any special projects of the medical society.

Submitted by Herbert A. Auer, Manager, MSMS Communications Department, under Doctor Burton's chairmanship.

Committee on Occupational Health

Duane L. Block, MD, *Chairman*

The last formal meeting of the Michigan State Medical Society Occupational Health Committee was July 30, 1969. Since that time members of the Occupational Health Committee have met with the Michigan State Medical Society

Committee on Mental Health to explore possible joint cooperative efforts in dealing with the problem of alcoholism. The Committee has informally explored methods of being helpful to the Detroit Mayor's Committee for Development of Human Resources.

The Committee Chairman corresponded with the Director of the Bureau of Workmen's Compensation regarding alleged problems involving physicians' participation in workmen's compensation administration.

A new Director will be appointed in the near future at which time the Committee plans to meet with him to explore mutual concerns and discuss previous Committee recommendations to improve the medical aspects of workmen's compensation.

Committee on Postgraduate Medical Education

HARRY A. TOWSLEY, MD, *Chairman*

The past year has been one of the busiest for the Committee on Postgraduate Medical Education with several subcommittees working on special assignments while the Committee continued to make available to the citizens the best of modern, scientific, medical services by providing continuing medical educational opportunities to the physicians of Michigan. The full Committee met December 11, 1969, March 25 and June 18, 1970.

Again, the Committee worked to provide a series of postgraduate educational programs in 18 communities across the state to help doctors improve their delivery of health care. A major innovation was added this year. After several experimental programs, the Committee this year provided programs in only those communities where the county medical society developed a wet-clinic-type of program in the afternoon at a local hospital. Faculty members from the three Michigan medical schools conducted the afternoon clinics and spoke at regular component society meetings in the evening. MSMS and the State Department of Public Health provided stipends and travel expenses to the speakers. These fall and spring programs serve physicians in the less populated communities in Michigan.

The Committee at each meeting discussed some of the new findings in the Physicians' Survey which was done in cooperation with the University of Michigan's Center for Research and Utilization of Scientific Knowledge (CRUSK) and the Department of Postgraduate Medicine. The Michigan Association for Regional Medical Programs financed the study. Results will be reported and interpreted in a series of special articles this fall in *Michigan Medicine.*

A subcommittee started a study of "the role of the computer in continuing medical education" and made one field trip to the Dow Chemical Company in Midland.

The Committee had spirited discussions and debates at two meetings on the feasibility of requiring Michigan physicians to complete certain postgraduate educational minimums as prerequisite for continuing MSMS membership and/or recertification by the state. A subcommittee was formed in the summer to develop criteria.

Four other matters are under consideration: (1) Study of ways to motivate practicing physicians to recognize the need for continuing education; (2) Study of methods of providing postgraduate programs which will appeal to both the specialist and the generalist; (3) Study of the many media available—such as journals, dial-in telephone systems, closed and open circuit radio and television, program-learning, etc.; (4) Study of evaluation techniques to evaluate scientific learning and improved patient care.

One small pilot project is underway whereby MSMS and the MARMP are sending selected Michigan physicians into two Upper Peninsula communities for short visitations on a regular, repeated schedule to help the physicians further improve the care of heart patients.

Committee on Professional Insurance Plans

ROBERT M. STOW, MD, *Chairman*

The Committee held its meeting on August 12, 1970.

MSMS Group Insurance Programs: There were two major developments this year in the MSMS group insurance program: The implementation of a Society-sponsored plan of umbrella-type excess liability insurance, and action to increase the available limits of group life insurance from $10,000 to $25,000.

The new "umbrella" coverage became available this spring to provide excess liability coverage above basic insurance in amounts of $1,000,000 to $5,000,000 applicable to professional liability, office premises, automobile, residence, etc. An excess major medical feature that supplements a basic health plan also was added.

A valuable advantage of the MSMS plan is the low requirement for basic professional liability insurance of $100,000/$300,000. Many similar plans require $200,000/$600,000 professional liability limits, which result in higher premium costs. The premium cost for the MSMS plan is less than comparable plans.

Professional Liability Insurance

The Committee is continuing its efforts to make sure that all ethical practicing physicians are able to secure professional liability insurance coverage at the lowest possible premiums. We have met with the President of the Medical Protective Company to discuss trends in claims and suits, and the availability and cost of coverage.

The Committee has established a close liaison with the AMA which is in the process of developing an AMA - State Society sponsored liability insurance program. We have this matter under active study and will make our recommendations to The Council at the proper time.

Committee on Public Health

MAURICE S. REIZEN, MD, *Chairman*

The Committee held one meeting on February 11, 1970, and because of the resignation of its chairman, Maurice S. Reizen, MD, the second meeting as recommended was not scheduled. Doctor Reizen submitted his resignation because of his appointment as Director of the Michigan Department of Public Health.

The Committee adopted the "Suggested Minimum Schedule for the Active Immunization of Infants and Children and Tuberculin Testing" and has recommended that it be used. This recommendation of the Committee was approved by The Council and the information was printed in *Michigan Medicine.*

The scope of the Committee was expanded to include respiratory diseases, aging, venereal disease, blood banks, diabetes and iodized salt.

The Committee was concerned with environmental pollution and had a discussion with a representative of the Water Resources Commission, Department of Natural Resources, State of Michigan, and sent representatives to the meeting sponsored by the Ontario Medical Association in an attempt to get a united international effort to control pollution in the Great Lakes area. The Committee adopted an official "Policy Statement on Environmental Pollution" of the Michigan State Medical Society, which has been approved by The Council. Other projects of the Committee are: Physical status card; perishable product dating; snowmobile deaths and injuries; smoking and health; paramedical personnel functions and their relationship in the delivery of medical services, dangerous communicable diseases, and congenital rubella syndrome.

It was also recommended that an "Environmental Health Corner" be established in *Michigan Medicine* to enable physicians to keep abreast of developments in this vital area.

Committee on Public Relations

BROCK E. BRUSH, MD, *Chairman*

The MSMS Committee on Public Relations met April 15, 1970 to consider projects, and met with the MSMS Committee on Medical Socio-Economics and the MSMS Committee on Government Programs on May 13, 1970 and on June 17, 1970. The three Committees held two long workshops to explore ways to improve health care in the inner city and to develop an MSMS counseling and negotiating service.

As in the past, the work of the Committee and the public relations efforts of The MSMS Council are closely related by the MSMS Staff and Officers.

The Committee and staff members carried on liaison with many organizations, schools, universities, legislators, etc., to deepen channels of communications and to facilitate efforts to improve the health care of the people of Michigan. MSMS provided assistance and guidance to many component county medical societies.

MSMS continued to provide a special grant to the Michigan Health Council to operate the Health Careers Mobile. The mobile unit, developed first by MSMS in 1965, now travels to schools, community events, summer fairs, etc., to provide information and inspiration to students considering careers as physicians and health-related personnel.

The series of radio programs prepared by MSMS on various health subjects continued during the year, with the University of Michigan radio station, WUOM, distributing the tapes to about 25 Michigan radio stations. In addition, MSMS sent copies of radio tapes and newspaper columns, called the "Human Side" by Hugh W. Brenneman to interested stations, and weekly and daily newspapers. Until his resignation, Mr. Brenneman moderated a television program, "Formula," over a Lansing station, WJIM-TV, each Sunday night—often on medical subjects. The series was taken over by the Michigan Health Council with another moderator in July.

The Committee provided leadership for an expanded Community Health Week in October. This AMA-sponsored, national project was implemented in Michigan by MSMS, the Michigan Health Council, and the Michigan Association of the Professions. This year, many other organizations cooperated in promoting the need for more physicians and health personnel.

Two public forums were sponsored during 1969-70 by MSMS, the Wayne County Medical Society, and *The Detroit News*, following the first in the series last spring on "Arthritis." The fall forum on "Diabetes" was held in the evening during the MSMS Annual Scientific Session in Detroit. In the spring, a Saturday afternoon forum on "Health Careers" was held with the cooperation also of the Michigan Health Council, Michigan Medical Service, and several other related groups. Information about these public health forums was submitted by Herbert Auer of the MSMS staff to the 1970 Adult Education Association of Michigan "Creativity in Adult Education" Contest. The Forum project was judged as the best of many entries from universities, business, industry, organizations, etc., and duplicate awards were presented by AEA-M to MSMS, WCMS, and *The Detroit News*.

Some other comments about the MSMS communications efforts appear in Part I of the Annual Report of The MSMS Council.

Committee on Rural Medical Service

DONALD R. MCCORVIE, MD, *Chairman*

The Committee met on May 20, 1970, following a roundtable discussion on doctor availability at the MSMS Workshop for Medical Leaders.

Discussion disclosed that nearly every region in Michigan had held a Health Careers Conference during the year, and that many had hosted the Health Careers Mobile. Nearly 4,000 students applied for 387 openings in medical schools. Mr. John Doherty, of the Michigan Health Council, reported an increase of nearly 2,000 doctors of medicine during the decade, but Michigan needs 600 more family physicians and 1,400 more medical specialists.

Chairman McCorvie reported on the 23rd Annual AMA Conference on Rural Health. Michigan has been selected as a possible host for the National Conference on Rural Health in 1974.

The Committee approved the following concepts:

1. Encourage Michigan Legislature toward greater financial support of medical school needs.
2. Encourage medical schools toward a greater emphasis in curriculum on family physician.
3. Encourage involvement of Michigan students, AMA members in rural health projects in Michigan.
4. Support programs aimed at development of physician assistant.
5. Develop an MSMS counseling service aimed at local medical communities developing area health planning.
6. Agree that SAMA representatives from Michigan's three medical schools be invited to attend the next meeting of the Rural Medical Service Committee.

18. Reports of House of Delegates Committees

Committee on Certificates of Commendation

H. ROSS HUME, MD, *Chairman*

The MSMS House of Delegates in 1961 established the "MSMS Certificates of Commendation." The original action instructed that the awards "may include both scientific and/or public service, and may be awarded to one or several physicians annually who distinguish themselves in the medical profession."

The 1962 House of Delegates presented the first four such awards, and a number of awards have been recommended each year by committees and approved by the delegates. A complete list of awardees is attached for the review of the delegates.

This year, the Committee sent two invitations to each component county medical society inviting nominations. The Committee carefully evaluated 23 physicians, who had been recommended. The selection was most difficult because the information was sketchy in some cases. The Committee in the future will request two letters of support to accompany the nomination form; one letter from a physician and one from a non-medical person.

The Committee is proud this year to present the names of six distinguished Michigan physicians for Certificates of Commendation. They are:

Hira E. Branch, MD, Flint
Muir Clapper, MD, Detroit
Harold F. Falls, MD, Ann Arbor
Herbert W. Harris, MD, Lansing
Robert E. Rice, MD, Greenville
Sarah Schooten, MD, Detroit

Biographic information about each of the nominees follows: Hira E. Branch was born in Otisville, Michigan on December 9, 1907. He attended Albion College and received his medical degree from the University of Michigan in 1932. Doctor Branch completed his internship at Harper Hospital, Detroit. He practiced three years in Detroit and served on the staffs of Harper, Children's, Grosse Pointe and Mt. Carmel hospitals from 1937-40. He completed a residency in orthopedics and orthopedic surgery at Harper, Children's and Herman Kiefer hospitals, all in Detroit.

Doctor Branch began his practice in Flint in 1940 and has practiced orthopedic surgery there for 30 years. He established the orthopedic services at Hurley, St. Joseph and McLaren hospitals. He is in charge of the Rotary Orthopedic Clinic in Flint, and is an orthopedic consultant to the C. S. Mott Foundation and the Mott Health Center.

Doctor Branch, who serves as chairman of the MSMS Committee on International Health, has made several visits to help overseas programs. In 1963, he was an instructor in orthopedics at Cho-Ray Hospital and the Medical School at Saigon where he also operated clinics. Then in 1966, he did orthopedic surgery in Malaysia; and in 1969-70 spent two months as an orthopedic instructor at the University of

Indonesia at Djakarta. He has been active in the Medico-Division of CARE project.

Doctor Branch also has presented a number of lectures at international and foreign orthopedic conferences in Canada, Mexico and Austria. Doctor Branch has had a number of scientific papers printed and has lectured on the AMA clinical program.

He received a Citation and U.S. Army Commendation Ribbon in 1945; a Medico Certificate of Appreciation; a Certificate of Appreciation from the AMA for service in Vietnam; and a Citation from the United States House of Representatives in 1966 for his interest in international health. In 1969, Albion College presented him a Distinguished Alumni Award, and this year on May 1, he received the Liberty Bell Award in connection with Law Day.

Muir Clapper was born in Detroit May 26, 1913 and is a lifelong resident of the Motor City. He received his bachelor's degree in 1933 and his Doctor of Medicine from Wayne State University in 1937. He received a Master in Science in Internal Medicine from Wayne in 1940.

His graduate training included his internship, City of Detroit Receiving Hospital; Residency, Assistant in Medicine, Receiving Hospital; Residency, Chief, in Medicine, Receiving; and later, work in tropical medicine at the Army Medical School.

Doctor Clapper has been a devoted teacher at Wayne State University, earning the respect and admiration of many classes, interns, residents and colleagues. He began at Wayne as a special instructor in medicine, then was promoted to instructor in medicine, assistant professor, associate professor, and then named a full Professor of Medicine in 1953. He was acting chairman of the Department of Medicine from 1957-59.

Doctor Clapper has been chosen for many positions of leadership responsibility at the WSU School of Medicine. He was president of the Medical School of Faculty Senate for three years; a member of the Medical School Alumni Association Board of Directors for four years, a member of the Dean's Committee at the Medical School for a number of years, and a member of the Detroit General Hospital Executive Committee for five years.

He has been a senior attending physician at Detroit Receiving since 1951, a consultant in medicine at the Veterans Hospital, Detroit Memorial, Harper, Jennings, and Blain hospitals. He has been medical advisor to the Bureau of Hearings and Appeals of the U. S. Department of Health, Education and Welfare since 1967. Doctor Clapper served more than 20 years as consultant in internal medicine for the United States Public Health Service Hospital.

Doctor Clapper long has been prominent in the Michigan Heart Association, serving as president in 1962-63. He served on the board of directors of the American Heart Association for several years. He is a past president of the Detroit Heart Club.

He is a former Governor of the American College of Physicians for Michigan and a member of the board of trustees of the Michigan Society of Internal Medicine. His many accomplishments include serving as chairman of the AMA Section on Internal Medicine.

Certified by the American Board of Internal Medicine, he is a Fellow, American College of Cardiology, and Fellow, American College of Physicians. There are many other entries in his Curriculum Vitae under the heading of "Medical Societies, Committees, Chairmanships, Etc."

Harold F. Falls was born in Winchester, Indiana on November 26, 1909. He received a bachelor's degree from the University of Michigan in 1932 and then his medical degree there in 1936. He did his internship at the University Hospital, then his residency in ophthalmology, and obtained his M.S. in ophthalmology in 1939.

Doctor Falls has been associated with the University of Michigan Medical School and Medical Center for 30 years. He was an instructor, assistant professor and associate professor and has been a full professor since 1959. He also is a research associate in the department of human genetics.

He was certified by the American Academy of Ophthalmology and Otorlaryngology in 1940 and has been a Diplomate of the American Board of Ophthalmology since 1942. For many years he has been a consultant at St. Joseph Mercy Hospital, Veterans Administration Hospital and Wayne County General Hospital, and with the National Society for the Prevention of Blindness, Michigan Chapter.

His list of awards and honors includes the Billings Gold Medal for his scientific exhibit at the American Academy of Ophthalmology and Otolaryngology and the Lucien Howe Medal presented at the 1970 AMA Convention in Chicago. He has written more than 20 chapters in various medical textbooks and has more than 85 scientific articles to his credit.

Doctor Falls has been a leader in the affairs of the University of Michigan and the University Hospital, serving on numerous committees. He is now chairman-elect of the senior medical staff and recently served as chairman of the Medical Center Centennial Committee.

President of the Washtenaw County Medical Society 10 years ago, he continues to serve in key positions. A former Vice Speaker of the MSMS House of Delegates and a delegate for many years, he has just completed a term on the MSMS Council as a Councilor. His MSMS record of service also includes terms as Chairman of the MSMS Committee on Insurance, chairman of the MSMS Medical Care Study Committee, Chairman of the MSMS Medical Socio-Economics Committee.

Doctor Falls is a past chairman of the Association for Research in Ophthalmology, former vice-president of the American Society of Human Genetics, and a past president of the Michigan Ophthalmological Society.

A delegate from MSMS to the AMA House of Delegates, Doctor Falls serves on the AMA Council on Health Manpower and the AMA Commission to Coordinate Relationships of Medicine and the Allied Health Professions.

Herbert W. Harris was born in Malta, Ohio, on April 9, 1900. He attended Ohio University and received his degree in medicine from the University of Cincinnati in 1927. He completed his internship at the Miami Valley Hospital, Dayton, Ohio, and his residency in orthopedics at the University of Michigan.

A specialist in orthopedics, Doctor Harris has practiced in Lansing since 1941. He served as chief of staff two years at St. Lawrence Hospital during a community-wide hospital expansion campaign; and has been chief of orthopedics at both St. Lawrence and Sparrow hospitals. Doctor Harris has worked for the disadvantaged child, working for many years with the Michigan Crippled Childrens Commission.

A former lieutenant colonel, Doctor Harris was chief of the orthopedic section, 17th General Hospital. He received the Bronze Star and the Order of Crown from Italy.

Doctor Harris was president of the Ingham County Medical Society in 1959 and has served since as a delegate to the MSMS House of Delegates. He was instrumental in convincing his county medical society to make a substantial financial contribution to a new year-round camp for teenage boys. The "Highfields" project is one of his favorite causes. He is chairman of the Finance Board of the Ingham County Medical Society, administering a sizeable scientific trust fund.

Doctor Harris has contributed uncounted hours to his medical profession and the people of Michigan by serving as a member of the Board of Directors of the Michigan Hospital Service. He has held this position for 11 years.

Highly regarded as a citizen of Lansing, he is an elder in the First Presbyterian Church, and has been a member of the Rotary Club for 18 years.

Robert E. Rice was born in Celina, Ohio on February 11, 1920 and he attended Central Michigan University before enrolling at the University of Michigan. He obtained his degree in medicine there in 1944 and interned at the U. S. Naval Hospital, Oceanside, California. After his service in the U. S. Navy Medical Corps he came to Greenville in 1947 and has practiced there since as a generalist.

Doctor Rice is former chief of staff, chief of OB, and chief of medicine at the United Memorial Hospital in Greenville. This past summer, he was responsible to coordinate the training program for a Wayne State University sophomore medical student who spent 10 weeks at the hospital in the new SAMA program, co-sponsored by MSMS and the Michigan Hospital Association.

A past president of the Ionia-Montcalm County Medical Society, he serves as a delegate from the county to the MSMS House of Delegates. He is a delegate from MSMS to the AMA House of Delegates and has served as vice-chairman of the Michigan delegation.

Active in MSMS affairs, he served several years as chairman of the Committee on Rural Medical Service and represented MSMS at the AMA Rural Health Conferences.

Widely known for his concern about rural medical practice, Doctor Rice is one of the physicians who serves on the Medical Advisory Committee of the Sears-Roebuck Foundation. He is now chairman of the important MSMS Committee on Government Medical Care Programs. He is past president of the Ionia-Montcalm County Chapter of the American Academy of General Practice.

Doctor Rice has contributed much to the Michigan Health Council, as a leader in its career recruitment work, and as chairman of the Advisory Committee on Smoking and Health.

Doctor Rice is very prominent in community work in Greenville. He is president of the Greenville Board of Education, and past president of the Board of Directors of the Congregational Church. He has been a member of the Board of Directors of the Greenville Chamber of Commerce. A past president of the Greenville Lions Club, he formerly served as District Governor of Lions International.

Active in Scouts, 4-H work, and conservation, Doctor Rice has been the team physician at Greenville High School for more than 20 years.

The Governor has appointed Doctor Rice three times to state-wide commissions. He is a member of the Governor's Commission on Mental Health, the Governor's Commission on Migrant Labor, and the Governor's Committee on Agricultural Labor.

He serves as a medical advisor to the American Cancer Society, and is the chief medical examiner in Montcalm County.

Sarah Schooten was born in Burma, India, on October 1, 1894 where her parents served as missionaries. She attended grade school in Chile and was graduated from the Methodist High School in Hackettstown, New Jersey. She went to Germany to study medicine in the summer of 1914 and when the medical schools were closed after World War I was declared she joined the Red Cross there. In 1916 she married a Dutch Sea captain, who was killed when his ship was sunk by a German submarine. She gave birth to a daughter and returned to Chile to teach. Later she returned to the states and received her MD from what is now Wayne State University.

She began her career in Detroit in 1924 at Providence Hospital as the first woman intern. As well as being on the staff at Providence, she is on the staff of Crittenton, Grace, Highland Park General and several other hospitals. Now 75 years young, she keeps office hours five days a week at the Nine Mile Medical Building.

Doctor Schooten has been the pediatrician to the children of St. Vincent and Sarah Fisher Home for the past 42 years, and also serves on its board of directors.

Long active in the Salvation Army as a community worker, she was honored in 1946; and then in 1968, she became the fourth Detroit person ever to receive the William Booth Founders Award—the highest award of the Salvation Army. She is on the board of the Salvation Army Children's Home in Detroit, where she has treated the children for 43 years.

Doctor Schooten has spent many, many Wednesday nights at the St. Francis Cabrini Clinic where her knowledge of Spanish is a great asset. She can also speak Burmese, Hindustani, German and has a knowledge of Greek.

In 1960 Doctor Schooten flew to Korea to help dedicate a new wing to the Columban Hospital. While there, she adopted four children, whom she continues to help. She has sent seed, buffalo, fertilizer, chickens, pigs and other help to the poor people on the Island of Cheju Do in Korea. Early this year, she flew to Australia to represent America as a delegate to the Medical Woman's International Association. She was appointed this year by the Women of Wayne State to the board of directors of the Child Care Center which is helping mothers who are working on advanced degrees.

Doctor Schooten is a member of many medical and community groups, is listed in "Who's Who in the Midwest" and "Who's Who of American Women." Early this year she was selected by the Greater Detroit Chamber of Commerce as one of the "Ten Top Working Women of 1970."

THE HOUSE, acting as a committee of the whole, approved the report of the Committee. Subsequently, at the Tuesday evening banquet, Certificates of Commendation were presented to Doctors Branch, Clapper, Falls, Harris, Rice, and Schooten.

Committee on Compensation of Officers

JOHN J. COURY, MD, *Chairman*

This Committee was appointed by the 1968 House of Delegates to investigate the question of remuneration of MSMS officers.

Current MSMS policy provides for (1) special expense allowance of $1,000 annually for the President, Speaker, and Council Chairman and (2) reimbursement of out-of-pocket expense for authorized travel of all officers.

This Committee has met and studied this matter. The following individual opinions of committee members were summarized after extensive discussion:

1. The concept that an MSMS officer could earn increased income as a result of his office is inaccurate.
2. Physicians who depend on their practice for income should not be penalized if they desire to be an MSMS officer.
3. The privilege and honor to serve as an MSMS officer is now equated with financial liability and time-consuming dedication if there is to be effective leadership.
4. MSMS has been fortunate in securing services of members with outstanding qualifications and leadership ability.
5. Increasing the number of MSMS officers eligible for special expense allowances could possibly attract qualified, young physicians and result in increasing effective leadership.
6. State Societies are increasingly becoming officer-led and directed by institutional doctors which results in decreased representation of the private practitioner.
7. The profession is now undergoing transition that may radically alter traditional patterns and functions of medical associations.
8. It is essential that young physicians and students become interested in the political aspects of medical organizations.

As a result of our deliberations, the Committee makes the following recommendations to the House of Delegates.

Recommendation One: That special yearly expense allowances be authorized for various MSMS officers as follows:

President	$5,000 per year
President Elect	$100 per diem (not to exceed $2,400)
Speaker	$2,500 per year

Council Chairman	$5,000 per year
Secretary	$100 per diem (not to exceed $2,400)
Treasurer	$100 per diem (not to exceed $2,400)
Council Members	$100 per diem (not to exceed $2,400)

Recommendation Two: That these allowances be given in addition to the present Society policy of reimbursing out-of-pocket expenses.

Recommendation Three: That these allowances be available to these officers to use at their personal discretion.

Recommendation Four: That MSMS member dues be increased to cover these added expenses. (Further discussion pointed out that these recommendations if adopted would mean a maximum increased cost to MSMS of $64,700 per year).

THE REFERENCE COMMITTEE on Ways and Means, J. W. Moses, MD, Chairman, reported as follows:

"Your committee is in sympathy with the recommendations of the committee report.

"We, however, recommend disapproval of the recommendations for the following reasons:

1. **The suggested amounts of the reimbursement are not sufficient to compensate for the loss of income engendered in the performance of their duties.**
2. **It is recognized that the majority of physicians devote a considerable amount of their time to non-remunerative efforts in the support and promotion of medical programs.**
3. **It is felt at the present time our prime priorities lie elsewhere."**

THE HOUSE adopted the report of the Reference Committee but directed that the Committee on Compensation of Officers be reappointed.

Committee on Constitution and Bylaws

Paul R. Dumke, MD, *Chairman*

The 1969 House of Delegates considered the following Constitution and Bylaws changes and laid them over for final consideration by the 1970 House of Delegates:

1. *MSMS Purposes.* The following language changes in Article II, Section 1, of the Constitution, were given first reading and laid over until the 1970 Session for final action. This Committee recommends that the proposed changes be approved.

   ARTICLE II, PURPOSES, Section 1—PURPOSES.

   The purposes of this Society shall be:

   (1) To bring into one viable, effective organization the ethical physicians, licensed to practice in Michigan, in order that their contribution to human welfare will be enhanced.

   (2) To constitute, support and assist the American Medical Association in cooperation with similar societies of other states, in meeting its appropriate responsibilities and, in like fashion, to form constituent and component medical societies.

   (3) To conceive, develop and administer health educational programs designed to improve public understanding, awareness and acceptance of good medical standards, practices and concepts, as they relate to personal health, scientific progress and society's advancement.

   (4) To stimulate advancement of the science and art of medicine, and continually to seek to advance the medical, scientific, social, environmental, economic and medical political knowledge of its members in order that the doctor may better serve his patients and the public health generally.

   (5) To aid Michigan physicians individually and collectively in maintaining high levels of ethical conduct and standards of practice to protect and serve the total public.

   (6) To work with other medical and nonmedical groups and persons through individual members and as a corporate body toward stimulating progress in all aspects of health care in Michigan and elsewhere, thereby offering leadership toward meeting the health needs of the people.

   (7) To preserve voluntary medical practice, recognizing it as a most effective means of delivering quality health care.

   (8) To develop methods, techniques and practices that moderate the costs of quality medical and health care and provide for fair remuneration for services rendered.

   (9) To ensure the future of medical practice by attracting capable people into the medical and health professions and help arrange for the most effective distribution of their services.

   (10) To encourage medical students and physicians-in-training to participate in, understand, and help develop the purposes and goals of organized medicine in order that the total objectives of the profession be enhanced and accomplished.

   (11) To combat the efforts of all those who would denigrate the reputation and services of the medical profession.

   (12) To carry on such functions and activities as are deemed necessary or desirable to accomplish effectively the above purposes; provided, however, that the Society shall engage in no activities which cannot be construed as relevant, incidental, or necessary to its charitable, educational, or scientific purposes.

2. *Treasurer and Secretary—Power to Vote.* The following language changes in Article X of the Constitution, and in Chapter 10, Section 2 of the Bylaws, were given first reading and laid over uutil the 1970 Session for final action. This Committee recommends that the proposed changes be approved.

   Proposed Constitutional Amendment: Amend Article X —The Council, Section 1—Composition—Powers and Duties, as follows:

   "The Council shall be the executive body of the Society. It shall consist of one Councilor from each Councilor District or one Councilor for each ten delegates when the number of delegates from a district exceeds ten, the President, President-Elect, Immediate Past President, SECRETARY, TREASURER, Speaker and Vice Speaker of the House of Delegates. ~~The Secretary and Treasurer shall also serve on The Council without power to vote.~~ It shall have the custody and entire control of all funds and property of the Society and shall act for the Society as a whole and for the House of Delegates between Sessions."

   Proposed Bylaws Amendment: Amend Chapter 10—The Council, Sec. 2—Executive Committee, as follows:

   "The Executive Committee of The Council shall consist of the President, the President-Elect, the Speaker of the House of Delegates, the Vice-Speaker of the House of Delegates, the Chairman of The Council, the Vice-Chairman of The Council, THE SECRETARY, THE TREASURER, the Chairman of the Finance Committee, the Chairman of the County Societies Committee and the Chairman of the Publication Committee. ~~The Secretary and the Treasurer shall also serve thereon without power to vote.~~"

In considering the foregoing amendments, the 1969 House of Delegates said that the Secretary and Treasurer should be "nominated by The Council and/or the House of Delegates and elected by the House."

The meaning of "and/or" in this statement is open to so many interpretations that the Committee could not draft appropriate Bylaws amendments for consideration by the 1970 House.

Therefore, the Committee recommends that the question of the election of the Secretary and Treasurer, terms of office, and method of nomination, be referred to the Committee on Constitution and Bylaws for further study and report to the 1971 House of Delegates.

3. *Right to Vote for Specialty Section Delegates.* (Resolution 80, 1969 House of Delegates.) The following language changes in Chapter 9 of the Bylaws were given first reading and laid over until the 1970 Session for final action. The Committee recommends that the proposed changes be approved.

    Chapter 9, Section 1. COMPOSITION—Add after the first sentence "and each recognized specialty section," the sentence to read: "The House of Delegates shall be composed of members elected by the component county societies and each recognized specialty section." Chapter 9, Section 2. DELEGATES-AT-LARGE—EX-OFFICIO MEMBERS—Delete "and one delegate from each authorized section," the sentence to read: "The officers of this Society, and the members of The Council shall be ex officio members of the House of Delegates,".

    Chapter 9, Section 3. ELECTION—CERTIFICATION —To be added after the words "component county society" the following: "or recognized specialty section," the sentence to read as follows: "Promptly after election the secretary of the component county society or recognized specialty section shall certify the names of its delegates and alternate delegates to the Secretary of this Society."

THE REFERENCE COMMITTEE on Constitution and Bylaws, David J. Millard, MD, Chairman, recommended approval of the report of the Standing Committee on Constitution and Bylaws, with the exception of that portion dealing with the election of the Secretary and Treasurer. The Reference Committee recommended the following changes in the Constitution and Bylaws:

"ARTICLE IX, Section 3. (The last sentence to be changed to read):

The Secretary, Assistant Secretary, Treasurer, and Assistant Treasurer shall be nominated by The Council and elected by the House of Delegates in the manner and for such terms as are prescribed by the Bylaws.

"CHAPTER 9, Section 12. (Changed to read):

ELECTION OF OFFICERS—Election of officers of the Society, ~~except that of the Secretary, Assistant Secretary, Treasurer, and Assistant~~ Treasurer, shall take place at the last meeting of the House of Delegates at each Annual Session. All nominations shall be made from the floor of the House with the exception of Secretary, Assistant Secretary, Treasurer, and Assistant Treasurer who are nominated by The Council. . . .

"CHAPTER 10, Section 1. (Changed to read):

ORGANIZATION—The Council is the executive body of the Society. Subject only to the following: it shall determine the times and places of its meetings. It shall nominate candidates for Secretary, Assistant Secretary, Treasurer, and Assistant Treasurer to be elected by the House of Delegates who shall serve for a term of office of one year or until a successor is elected and takes office. It shall hold an Annual Meeting in January of each year at which time it shall elect an Editor of the Journal of the Michigan State Medical Society, to take office immediately and to serve for a term of one year or until his successor is elected and takes office. . . ."

THE HOUSE passed on first reading these Constitution and Bylaws changes. In accordance with Bylaws provisions, they were laid over to the 1971 session.

Committee on Procedures of the House of Delegates

Noyes L. Avery, Jr., MD, *Chairman*

This Committee has functioned since 1963 for the purpose of reviewing the operation of the House of Delegates and making recommendations to the Speaker. The Committee appreciates the interest shown by Speaker Blodgett in its deliberations and fully supports his plans for streamlining the operation of the House of Delegates.

Again this year, we have suggested that should any disruptors attempt to interfere with the orderly business of the Annual Meeting, the Speaker institute appropriate security and, if necessary, temporarily call a recess.

After much study, we have concluded that this year the Michigan Medical Service Corporate Meeting should be held within the framework of the House of Delegates. We have suggested Tuesday, September 22, from 10:30 am to 2:00 pm. We further recommend again that MMS explore the possibility of shortening its voting procedure and second, that it hold a business luncheon without reception so as to get maximum advantage out of this time period.

The Committee endorses the Speaker's plan for omitting the verbal presentation of certain reports and the referral to Reference Committees of only those items requiring House action.

The Installation Dinner should be a regular meeting of the House and utilized as desired by the Speaker and, by so doing, we feel that the House can expedite its work so that the only item of business remaining after this dinner on Tuesday evening will be the elections.

THE REFERENCE COMMITTEE on Resolutions, Robert M. Stow, MD, Chairman, recommended that the report be approved and Doctor Avery and his Committee be commended.

THE HOUSE approved the report of the Reference Committee.

Committee on Relationship of Specialty Societies in the House

Frederick C. O'Dell, MD, *Chairman*

In response to Resolution 80 passed by the House of Delegates in 1969, this Committee was appointed by the Speaker of the House to Study the Relationship of Specialty Societies to the House of Delegates of the Michigan State Medical Society.

The Committee concurs that each specialty section be given the right to vote in the House of Delegates, and suggests one voting delegate to represent each specialty section. Accordingly, the committee is in agreement with the proposed amendments to the Bylaws.

The Committee recommends that each specialty section be contacted for their recommendations in regard to subjects and speakers for the scientific sessions of the Society.

We also believe membership in the various specialty societies should be on record with the Michigan State Medical Society.

THE REFERENCE COMMITTEE on Constitution and Bylaws, David J. Millard, MD, Chairman, recommended approval of the report.

THE HOUSE approved the report of the Reference Committee.

Committee to Study Nominating Procedures of the House

Donald N. Sweeny, Jr., MD, *Chairman*

This Ad Hoc Committee was appointed by the 1969 House of Delegates to study the nominating procedures for electing officers of the House of Delegates of the Michigan State Medical Society. The Committee submits the following report.

1. OFFICERS: (President-Elect, Speaker of the House of Delegates and Vice Speaker of the House of Delegates). The election of these officers is at present time guided by Article IX Section 3 of the Constitution and Chapter 9 Sections 5 and 11 of the Bylaws.

    It is the consensus of this Committee that no changes be made in the method of nomination or election of these officers except that the nominations be made at the Third Session of the House and the election of these officers, from the list of candidates and any additional nominations, take place at the Last Session of the House at each Annual Session.

2. COUNCILORS: The election of Councilors is at present time guided by Chapter 9 Section 10 of the Bylaws.

   It is the consensus of this Committee that the election of Councilors should be the prerogative of the Councilors Districts. Nomination and election of Councilors shall be by the delegates from the Councilor Districts in which vacancies occur. Each component County Society in a Councilor District shall be notified that such an election is to take place in the present manner.

   The Councilors so elected shall be presented to the House of Delegates for approval at the Last Session of the House. If a vacancy occurs because of disapproval, the seated delegates of such a Councilor District shall caucus, elect a Councilor and submit him for approval in a similar manner before conclusion of the House of Delegates.

3. ELECTION OF DELEGATES TO THE AMERICAN MEDICAL ASSOCIATION: The election of delegates and alternates to the American Medical Association is at present guided by Chapter 9 Section 11 of the Bylaws.

   It is the consensus of this Committee that no changes be made in the method of nomination or election of delegates and alternates to the AMA except that nominations be made at the Third Session of the House. Election of delegates and alternates, from the list of candidates and any additional nominations, shall take place at the Last Session of the House at each Annual Session.

The Ad Hoc Committee further feels that the Reference Committee on Constitution and Bylaws of the Michigan State Medical Society should be directed to make changes in wordage of the Constitution and Bylaws in appropriate sections to accommodate these recommendations.

Having met, considered and submitted, the Ad Hoc Committee prays that it be relieved of its assignment.

THE REFERENCE COMMITTEE on Constitution and Bylaws, David J. Millard, MD, Chairman, presented the following report:

"(1) OFFICERS: This Committee recommends no further changes in the Constitution or Bylaws be made at this time in regard to the election of officers. It is suggested, however, that the speaker give serious consideration to recommending the nominations of officers at the third meeting, or at a meeting prior to the last meeting, of an annual session of the House.

(2) COUNCILORS: This Committee recommends that no change be made in the method for nomination and election of councilors as suggested in the Committee Report.

(3) ELECTION OF DELEGATES TO THE AMERICAN MEDICAL ASSOCIATION: The Committee feels that no change in the Constitution or Bylaws is required at this time. It is recommended that the speaker consider change of the agenda to accept nominations at an earlier meeting of the House as recommended by the Council Committee."

THE HOUSE approved the report of the Reference Committee.

RESOLUTIONS

● RESOLUTION 1

Shortage of Physicians
Worth W. Henderson, MD, Oakland County

HOUSE ACTION: Disapproved

Whereas, the cost of medicine to the American people is increasing at an over-expanding rate, and

Whereas, there is a definite shortage of physicians to supply these services, and

Whereas, many of the citizens and communities of Michigan are without the services of a qualified physician; therefore be it

RESOLVED: That the Michigan State Medical Society urge the State Legislature and the regents of our medical schools to double immediately their annual enrollment of students seeking the doctor of medicine degree.

● RESOLUTION 2

Reduce the Premedical Requirements for Matriculation in Medical Schools
Worth W. Henderson, MD, Oakland County

HOUSE ACTION: Adopted As Amended

Whereas, there is a definite need for an increasing number of physicians to supply our expanding population, and

Whereas, the cost of medical education, including pre-medical, medical, etc., is increasing annually, and

Whereas, the teaching of basic sciences can be designed to integrate most of the present pre-medical requirements, and

Whereas, the need for four years of pre-medical education is probably overemphasized; therefore be it

RESOLVED: That the Michigan State Medical Society urge the Regents of our medical schools to accept as full time students in medicine those with a minimum of two years of pre-medical education with a major emphasis on the humanities and social sciences.

● RESOLUTION 3

Urge Michigan Medical Service (Blue Shield) to Adopt and Use *AMA CPT, '70 Edition*
John B. Bryan, MD, Oakland County

HOUSE ACTION: Adopted As Amended

Whereas, adequate definition and description of the great variety of medical services now being used has long been a need of medicine, the insurance industry and organized medicine have agreed that a new system relevant to the practice of medicine today and taking into consideration the needs of the future should be developed. To meet these needs, the American Medical Association has recently revised its Current Procedural Terminology (CPT), recognizing the expertise developed by the California Medical Association (CMA) in revising the California Relative Value Studies. The AMA has worked closely with the CMA and specialty societies in developing the new CPT. The coding system is an expanded numerical system using five-digits instead of the old four, giving greater latitude and leaving many openings for the insertion of new services and procedures which will undoubtedly develop in the future, and

Whereas, a uniform description of services is necessary when dealing with the insurance industry, since their function of paying the bills for these services can be fulfilled only if there is uniform description of the services and if uniform code numbers are assigned to the described services; therefore be it

RESOLVED: That Michigan State Medical Society adopt *AMA CPT, '70 Ed.*, retire the outmoded *MRVS* and urge Michigan Medical Service (Blue Shield) to use the *CPT, 1970 Ed.* for reporting of all services rendered to its subscribers (including Medicare and Medicaid) and determination of payments for these services. "The implementation of this Recommendation to be accomplished when financially feasible and in Concert with the National Association of Blue Shield plans."

● RESOLUTION 4

Divestiture of Control of Blue Cross - Blue Shield Program
John J. Rick, MD, Branch County

HOUSE ACTION: Disapproved

Whereas, the need for physician control of the Blue Cross -

Blue Shield Program is a conflicting interest to the physicians of Michigan, and

Whereas, the Blue Cross - Blue Shield are well enough established not to require the further support of the Michigan State Medical Society, and

Whereas, the Blue Shield - Blue Cross programs are now representing governmental agencies which are responsible for payment of various governmental programs independent of physician approval; therefore be it

RESOLVED: That MSMS divest itself of all interest in the Michigan Blue Cross - Blue Shield Program as soon as possible.

● RESOLUTION 5

Michigan Blue Shield
John T. Geneczko, MD, Bay-Arenac-Iosco County

HOUSE ACTION: Disapproved

Whereas, Michigan Blue Shield has increasingly become less responsive to the opinions and guidance of the MSMS, and

Whereas, most policy decisions affecting consumer and physician have been formulated by executive session, and submitted to the Board of Directors after enactment, and

Whereas, Michigan Blue Shield has failed to fulfill its statements to the medical profession and consumer, the usual, reasonable and customary fee would be paid, and

Whereas, Blue Shield has reduced fee schedules without informing the consumer, and in some instances creating the impression physicians' fees have in essence increased, thus undermining patient-physician relationships, and the public confidence in the medical profession, and

Whereas, Blue Shield plans have failed to provide the desired buffer between physicians and governmental administrated programs, and have tended to increase the demand for a national government administrated health insurance; therefore be it

RESOLVED: That the Michigan State Medical Society (1) sever its seemingly close relationship with Michigan Blue Shield, (2) advocate Blue Shield's conversion to an indemnity insurance carrier status, as all other health insurance carriers in Michigan.

● RESOLUTION 6

Change Health Insurance Contract for Members and their Employees
John B. Bryan, MD, Oakland County

HOUSE ACTION: Adopted As Amended

Whereas, recent increases in premium rates and alleged "bad experience" have made the cost of MSMS group contract (BC-BS) excessive, and

Whereas, adequate medical coverage may be afforded at less cost to the members of MSMS and their employees by contracting for a "comprehensive program" with "deductible and coinsurance" payments of "usual, customary and reasonable" charges for covered services each year, and exclusion of some indemnification of certain services (e.g. maternity care); therefore be it

RESOLVED: That the Michigan State Medical Society Council be directed to study such available plans offered by some "Blue" Plans (e.g. Kansas City) and other commercial carriers.

● RESOLUTION 7

Encouragement of Family Practice & Improved Physician Distribution
Clifford W. Colwell, MD, Genesee County

HOUSE ACTION: Following Substitute Resolution Adopted in Lieu of Resolutions 7, 13, 29, 50, 85, 96.

Whereas, both the AMA and MSMS have repeatedly concerned themselves with the shortage of physicians, especially the need for more adequate numbers to care for the disadvantaged, serve the more rural and isolated communities, and replenish the field of family or general practice, and

Whereas, there is general agreement among experts, both lay and medical, that at least part of this shortage is due to the fact that a large majority of each year's graduates are entering fields other than those of primary medical practice, and

Whereas, this tendency is fostered by the present system of medical education which among other facts makes it very difficult for a medical student to learn anything about general or family practice or to meet a physician acquainted with these fields in his medical school experiences; and

Whereas, the American Academy of General Practice has established training guidelines for family practitioners to the end that Family Practice is now a specialty in medicine, and

Whereas, these ends can never be obtained until a majority of our medical schools have fully developed Departments of Family Practice and medical graduates are more effectively encouraged to acquaint themselves with the challenges and satisfactions of these areas of practice before committing themselves to specialty training; therefore be it

RESOLVED: That MSMS through appropriate channels take every step possible to assure that the above objectives are met in Michigan, including a request to establish Departments of Family Practice in all the medical schools of the State, and be it further

RESOLVED: That such departments' objectives will not only be to instruct students in those techniques and skills peculiar to family medical practice, but also to act as an organizational medium to plan and carry out effective community-oriented and based training programs including preceptorships.

● RESOLUTION 8

MD of the Week Program
John T. Geneczko, MD, Bay-Arenac-Iosco County

HOUSE ACTION: Adopted

Whereas, the program for "MD of the Week" representatives to the Michigan Legislature has been enthusiastically received by the Legislature, and has improved the medical profession's liaison with legislators in matters affecting the profession; therefore be it

RESOLVED: That the MD of the Week program be continued with appropriate changes as may be advised by the Legal Affairs Committee, and be it further

RESOLVED: That physicians participating in the MD of the Week program be reimbursed for encountered expenses, but the honorarium of $300.00 be discontinued.

● RESOLUTION 9

Temporary Registration of Medical Doctors
Frederick C. O'Dell, Jr., MD, Alpena-Alcona-Presque Isle County

HOUSE ACTION: Adopted

Whereas, there is an acute shortage of physicians and difficulty in attracting suitable medical doctors to many areas throughout Michigan, the Medical Licensure Act on occasion, by not being able to grant temporary licensure, causes hardship to many communities; therefore be it

RESOLVED: That the Medical Licensure Act of Michigan be amended to allow physicians with proper credentials to be given temporary licensure at the discretion of the Board of Registration of Medicine until the usual licensure requirements can be fulfilled.

• RESOLUTION 10

Establishment of Counselling Service — Medical Socio-Economics
John T. Geneczko, MD, Bay-Arenac-Iosco County

HOUSE ACTION: Following Substitute Resolution Adopted in Lieu of Resolutions 10, 46, 47, 70 & 90

Whereas, there is increasing pressure for national health insurance, and

Whereas, the medical profession is unprepared to present realistic programs, and fee schedules to governmental administrators, and recognizing the urgency for the necessity of such preparedness; therefore be it

RESOLVED: That this House of Delegates instruct The Council to set up a Bureau of Economic Information forthwith, and be it further

RESOLVED: That such a Bureau be a single department devoid of other administrative duties, and be it further

RESOLVED: That the head of said Bureau be a person with sufficient experience and knowledge to accomplish the following aims:

1. To develop and analyze statistical data on a local and statewide basis pertaining to the economics of medical care.
2. To compare such data with material now furnished by governmental and other sources.
3. To make such data available to the state and competent medical societies and their members as desired.
4. Such other activities as may be designated by The Council or the House of Delegates.

• RESOLUTION 11

Adoption of Relative Value Guide by Blue Shield
John T. Geneczko, MD, Bay-Arenac-Iosco County
for the Section on Anesthesiology

HOUSE ACTION: Withdrawn

• RESOLUTION 12

Component Medical Societies Liaison with State Legislators
Paul Rowe, MD, Bay-Arenac-Iosco County

HOUSE ACTION: Adopted

Whereas, necessity of the times makes mandatory increasing involvement of the medical profession's interaction in legislative affairs, and

Whereas, most of the county medical societies have been deficient in liaison with area legislators; therefore be it

RESOLVED: That the Michigan State Medical Society encourage all component medical societies to follow the example of Kent County Medical Society, and establish a periodic liaison with area legislators to discuss problems affecting the health care system.

• RESOLUTION 13

Incentives to Practice in Areas of Need
D. Bonta Hiscoe, MD, Ingham County
Constitution and Bylaws

HOUSE ACTION: Following Substitute Resolution Adopted in Lieu of Resolutions 13, 29, 58. (The House also adopted a Substitute for Resolutions 7, 13, 29, 50, 85, 96.)

Whereas, we recognize that one of our primary problems in securing proper distribution of medical care is the pattern physicians tend to follow in choosing a place in which to practice, and

Whereas, Michigan State Medical Society believes in freedom of action and freedom of choice rather than in coercion, and

Whereas, the American Medical Association House of Delegates at its June 1970 meeting underscored the fact that shortages of medical manpower are not due merely to an insufficient number of health professionals across the board, but also emphasized that maldistribution of practitioners geographically, by profession and by specialty, is an equally important factor in depriving communities of adequate supply in the spectrum of health services, and

Whereas, there was demonstrated a capability of increased physician output during World War II from existing facilities and with existing modalities for teaching; therefore, be it

RESOLVED: That Michigan State Medical Society, through one of its Committees, investigate various incentives which could be used to encourage physicians to practice in areas where shortages are acute, and be it further

RESOLVED: That the Michigan State Medical Society and the Delegates to the AMA by all appropriate means urge medical schools to increase the use of their staffs and facilities to 12 months a year and to establish new facilities and expand staffs when feasible to alleviate the crisis facing the country of shortages of health services and personnel.

• RESOLUTION 14

Election of AMA Delegates
D. Bonta Hiscoe, MD, Ingham County
Resolutions

HOUSE ACTION: Disapproved

Whereas, flexibility and adaptability are required to insure continuing responsiveness to the changing medical scene, and

Whereas, MSMS needs a more democratic way to elect its officers than the present method which usually requires the endorsement of a single candidate who has been arbitrarily chosen, and

Whereas, we feel that for an elected representative accountability to his constituency is at least as important as continuity in office, and

Whereas, no hearings have been held and no recommendations have been made as of September 1, 1970, by the committee assigned to consider this problem; therefore be it

RESOLVED: That two candidates be nominated for each position when delegates and alternate delegates to the American Medical Association are to be elected; and be it further

RESOLVED: That we accept the recommendations of the 1969 House of Delegates Committee on Constitution and By-Laws that proper steps be taken to change the By-Laws so that Chapter 9, Section 11, the first sentence of Paragraph 3 should read: "At each Annual Session, two or more candidates shall be nominated for each vacancy to be filled by Michigan State Medical Society in the House of Delegates of the American Medical Association."

• RESOLUTION 15

Multiple Methods of Practice
D. Bonta Hiscoe, MD, Ingham County
Public & Professional Relations

HOUSE ACTION: Adopted As Amended

Whereas, our ability to dispense medical care is being overburdened by current demand, causing poor distribution of both services and personnel, and

Whereas, different problems require different solutions; therefore be it

RESOLVED: That MSMS recognize that there are currently many acceptable methods of practicing medicine, and be it further

RESOLVED: That as various programs evolve we strongly feel that multiple options for the delivery of medical care should remain open to physicians.

● RESOLUTION 16

Merger — Medical Socio-Economics Committee and Governmental Affairs Committee
Paul Rowe, MD, Bay-Arenac-Iosco County
Public & Professional Relations

HOUSE ACTION: No Action

Whereas, the Medical Socio-Economics Committee and the Governmental Affairs Committee have similar purpose and apparent duplication of effort; therefore be it

RESOLVED: That the Medical Socio-Economics Committee and the Governmental Affairs Committee be merged into one functioning unit.

● RESOLUTION 17

Health Examinations for Athletes
Robert H. Evans, MD, St. Joseph County

HOUSE ACTION: Adopted

Whereas, Resolution 7 of the MSMS House of Delegates was passed, recommending that the MSMS Committee on Medical Aspects of Organized Athletics urge the adoption of a policy requiring only one physical examination each at junior high school and at senior high school level for participation in interscholastic athletics, unless serious injury occurred, and

Whereas, this action was taken without consultation with the MSMS Committee on Medical Aspects of Organized Athletics, and

Whereas, this committee has been founded as a committee of persons with expertise or interest in the area of athletic medicine, and

Whereas, the Houses of Delegates of both MSMS and the AMA passed Resolutions 56 and 112 recommending the creation of athletic medical units in every high school, thereby recognizing the need for improved services in the area of athletic medicine, and

Whereas, the establishment of requirements for physical examinations for interscholastic athletics is a function of the Michigan High School Athletic Association and not MSMS, and

Whereas, expert opinion has been given to the MSMS Committee on Medical Aspects of Organized Athletics advising against the policy of decreasing the number of pre-season physical examinations and pointing out the serious medical-legal implications possibly resultant from such action, and

Whereas, it is recognized that the providing of physical examinations to participating athletics in some communities may present difficulties; therefore be it

RESOLVED: That MSMS Committee on Medical Aspects of Organized Athletics recommend that the annual physical examination of junior and senior high school athletes be continued to preserve the present high standards of health protection to high school athletes and that each component medical society review the current methods of delivery of this type of health care, and be it further

RESOLVED: That the MSMS Committee on Medical Aspects of Organized Athletics invite each component society to submit to it any problems that they may be experiencing in the proper administration of its program and to seek advice and assistance from the Committee in solving these problems; and be it further

RESOLVED: That the MSMS Committee on Medical Aspects of Organized Athletics recommend to the Michigan High School Athletic Association the adoption of a standard, adequate and uniform health reporting card which may become a continuing record of the youth's participation in sports; and be it further

RESOLVED: That the MSMS Committee on Medical Aspects of Organized Athletics should receive, for study, those matters which relate to this specific area of expertise.

● RESOLUTION 18

Individual Case Participation
Bruce D. Bauer, MD, Oakland County

HOUSE ACTION: Adopted

Whereas, individual case participation with Blue Shield is again jeopardized, and

Whereas, the House of Delegates of 1969 reaffirmed its support of said participation; therefore be it

RESOLVED: That the House of Delegates give its support to individual case participation.

● RESOLUTION 19

Non-Participating Physicians of Blue Shield
Bruce D. Bauer, MD, Oakland

HOUSE ACTION: Adopted As Amended

Whereas, physician participation in Blue Shield is voluntary, and

Whereas, subscribers to Blue Shield have free choice of physicians, and

Whereas, physicians render service to said subscriber; therefore be it

RESOLVED: That the House of Delegates of MSMS uphold the policy of nondiscrimination in payment to subscribers for services rendered by non-participating physicians.

● RESOLUTION 20

Preservation and Restoration of Great Lakes
C. A. Vandervelde, MD, Muskegon County
Public & Professional Relations

HOUSE ACTION: Adopted As Amended

Whereas, the Great Lakes are the largest and most beautiful bodies of fresh water throughout the World, and

Whereas, the Great Lakes are still the mecca for fishing, boating, and swimming in this Water Wonderland, and a prime source of drinking water, and

Whereas, these priceless waters are not yet polluted beyond restoration; therefore be it

RESOLVED: That the MSMS support all sound efforts to prevent further pollution of the Great Lakes, and be it further

RESOLVED: That the MSMS endorse in principle proposals for reclamation and restoration of polluted waters, and be it further

RESOLVED: That the MSMS urge enforcement of current laws related to this subject and that a copy of this resolution be sent to the Governor.

● RESOLUTION 21

Ambulance Personnel Training
Clarence Crook, MD, Washtenaw County

HOUSE ACTION: Adopted As Amended

Whereas, the experiences in Washtenaw County have demonstrated the value to the community and patient care by providing advanced training by physician instructors of ambulance personnel, policemen and firemen on a continuing basis; therefore be it

RESOLVED: That physicians be urged to take leadership in providing training of those persons concerned with the immediate care of the acutely ill or injured on a continuing basis.

● RESOLUTION 22

Approval of Radiation Health and Safety Act of 1970
Charles O. Long, MD, Ingham County

HOUSE ACTION: Withdrawn

● RESOLUTION 23

Professional Standards for Athletic Trainers
Henry A. Scovill, MD, Washtenaw County

HOUSE ACTION: Following Substitute Resolution Adopted in Lieu of Resolution 23 & 24.

Whereas, the American Medical Association and the Michigan State Medical Society have long recognized the importance of proper health supervision in providing athletics for participants and the relationship of such supervision to the promotion of the art and science of medicine and the betterment of public health is clearly evident, and

Whereas, in 1967, the AMA House of Delegates recognized the fine rapport developed between the Committee on the Medical Aspects of Organized Athletics and the National Athletic Trainers Association (NATA), they lauded the development of professional standards by the NATA and they further recommended that all athletic teams have the benefit of a professionally prepared athletic trainer as a part of the medical supervisory team. The AMA House of Delegates specifically approved the following recommendations that:

(1) The AMA recognized the importance of the role of the professionally prepared athletic trainer as a part of the team responsible for the health care of the athlete;

(2) The NATA be commended for its efforts to upgrade professional standards, since improved preparation and continuing education enable athletic trainers to work effectively with physicians in the health supervision of sports; and

(3) State and local medical societies and physicians individually be encouraged to help advance the professional goals of the NATA in their communities through appropriate liaison activities; and

Whereas, in 1969, the House of Delegates of both the AMA and MSMS urged the creation of athletic medical units in all schools having sports programs and that such units have athletic trainers or athletic health coordinators, and

Whereas, the NATA has just formulated an outstanding set of procedures for certification based on educational preparation, years of experience, continuing education, apprenticeship training and certifying examinations; all evaluated by a Board of Certification composed of physicians and qualified athletic trainers, and

Whereas, the MSMS Committee on Medical Aspects of Organized Athletics has unanimously approved this resolution; therefore be it

RESOLVED: That the MSMS go on record as officially recognizing NATA's certification procedures and certification board, and be it further

RESOLVED: That the Michigan State Board of Education where and when possible recommend to local boards of education the appointment of certified athletic trainers (NATA) to work with physicians in the important area of health and supervision of athletes.

● RESOLUTION 24

Appointment of Certified Athletic Trainers (Athletic Health Coordinators)
Henry A. Scovill, MD, Washtenaw County

HOUSE ACTION: Substitute Resolution Adopted for Resolutions 23 and 24—See Resolution 23

● RESOLUTION 25

Support of The Governor's Proposal for Control of Drug Abuse
Benjamin Jeffries, MD, Wayne County

HOUSE ACTION: Following Substitute Resolution Adopted in Lieu of Resolutions 25, 43 & 75.

Whereas, Governor Milliken submitted in a Special Message to the Michigan Legislature on February 19, 1970, a Proposed Drug Abuse Program, subdivided into the following sections: "Office of Drug Dependence and Abuse"; "Programs for Drug Traffic Control"; "Programs for Drug Abuse Education"; and "Programs for Treatment and Rehabilitation"; and

Whereas, the programs proposed by Governor Milliken are realistic, and, if implemented, could be effective in meeting the serious problem of drug abuse; therefore be it

RESOLVED: That the MSMS support these programs recommended by the Governor of the State of Michigan, and be it further

RESOLVED: That the MSMS Legal Affairs Committee encourage and support legislation necessary to implement these goals outlined by the Governor in his Special Message.

● RESOLUTION 26

Public Educational Programs on Drugs
Paul J. Connolly, MD, Wayne County

HOUSE ACTION: Following Substitute Resolution Adopted in Lieu of Resolutions 26 & 27.

Whereas, drug abuse now constitutes a serious health problem, and

Whereas, the drug problem involves all ages, socio-economic and racial groups, and

Whereas, there is an urgent need for authentic information to alert the public, and

Whereas, all practicing physicians should become well versed in the diagnosis, treatment and rehabilitation of patients suffering from the drug problems; therefore be it

RESOLVED: That the MSMS urge the Michigan Health Council, the Michigan State Board of Education, the Parent-Teachers Associations and all other appropriate public agencies to expand their educational programs on the health hazards of the drug problem, and be it further

RESOLVED: That MSMS urge all medical schools, hospitals and medical societies in this State to establish educational programs in the diagnosis, treatment and rehabilitation of patients suffering from drug dependence, and be it further

RESOLVED: That MSMS encourage its members to participate fully in such training programs.

• RESOLUTION 27

Postgraduate Training Programs on Drug Abuse and Drug Dependence
Brock E. Brush, MD, Wayne County

HOUSE ACTION: Substitute Resolution Adopted for Resolutions 26 and 27—See Resolution 26

• RESOLUTION 28

Medicaid Allowance for Immunization
Louis E. Heideman, MD, Wayne County

HOUSE ACTION: Adopted

Whereas, the State Medical Assistance Program is assigned to assist Michigan needy persons in paying expenses for a wide variety of medical services necessary to protect health, and

Whereas, immunization against communicable diseases is essential to protect the health of the individual and the community, and

Whereas, The Michigan Medical Assistance Program limits its reimbursement to the diagnosis and treatment of disease and prohibits reimbursement for preventive service; therefore be it

RESOLVED: That the MSMS seek an expansion of the Michigan Assistance Program to include reimbursement to physicians for immunization procedures for the medically indigent.

• RESOLUTION 29

Maldistribution of Physicians
Robert D. Allaben, MD, Wayne County

HOUSE ACTION: Substitute Resolutions Adopted—See Resolutions 7 and 13

• RESOLUTION 30

Coordination of Various Governmental Medical Care Programs
Louis R. Zako, MD, Wayne County

HOUSE ACTION: Adopted As Amended

Whereas, The House of Delegates of the AMA has adopted a resolution to expand its role in planning and developing programs for medical care, and

Whereas, federal, state, and county governments have over the recent years evolved a multitude of medical care programs, and

Whereas, it is quite evident there is much duplication of administrative personnel, governmental funds, and persons of population groups affected; therefore be it

RESOLVED: That the MSMS and the Delegates to the AMA make every effort to cooperate with various governmental agencies to eliminate overlap in medical care programs and to develop programs on the basis of sound planning and development.

• RESOLUTION 31

Reaffirmation of Michigan State Medical Society Policy Statement on Abortions
Charles E. Darling, MD, Wayne County

HOUSE ACTION: Adopted

Whereas, there is considerable public pressure to amend Michigan's abortion law, and

Whereas, the medical profession should provide guidance to the public on this medical issue, and

Whereas, the policy statement adopted by the 1968 House of Delegates clearly enunciates the position of the MSMS; therefore be it

RESOLVED: That this House of Delegates reaffirm its 1968 policy statement on abortions, as follows:

Therapeutic abortion is a medical procedure. Accordingly the MSMS recognizes this responsibility to render available scientific medical information with respect to therapeutic abortion to legislators, authorized committees, the public, and finally and most importantly patients. Nowhere in the progression of therapeutic abortion legislation or practice should sight be lost of the fundamental principle that the primary decision belongs to the patient. This decision must be based on an informed understanding of the nature and the consequences of the therapeutic abortion and should be coupled with the informed consent of the husband if any and the parents and/or legal guardian if the patient is a minor. The MSMS respectfully recognizes that some physicians because of moral or religious grounds oppose liberalization of the abortion law. Therefore, no physician or hospital should be compelled directly or indirectly to perform a therapeutic abortion.

In view of the above, the MSMS believes that therapeutic abortion may be authorized subject to the following conditions:

1. A licensed medical or osteopathic physician perform the abortion in an accredited hospital licensed by the state.

2. Two other doctors of medicine or osteopathy concur in writing that one of the following conditions exist:
   a) The abortion is deemed necessary to preserve the life of the pregnant female: or
   b) The abortion is deemed necessary to preserve the phyical or mental health of the pregnant female: or
   c) That the infant may be born with incapacitating physical deformity or mental deficiency: or
   d) That 3 doctors of medicine or osteopathy believe that the pregnancy resulted from forcible rape or incest.

3. MSMS does not condone the concept that an abortion be performed on demand of any unwanted pregnancy or as a means of birth control. We do believe, however, that in determining whether or not there is a risk to the pregnant woman's life or health account must be taken of the patient's total environment considering such factors as parity, contraceptive failure, socio-economic stress, or marital or family stress when a woman does request a therapeutic abortion.

• RESOLUTION 32

Hospital Facilities for Drug Dependence
George Mogill, MD, Wayne County

HOUSE ACTION: Adopted As Amended

Whereas, treatment facilities for the care of patients suffering from drug dependence are inadequate, and

Whereas, the patients should be treated in a medical facility where all other services are available, and

Whereas, there is a need for continued research as to the most effective modalities of treatment for drug dependence, and

Whereas, physicians should have clinical training in the diagnosis, treatment and rehabilitation of drug dependent patients, and

Whereas, the majority of patients suffering from this illness do not have funds to pay for their medical care; therefore be it

RESOLVED: That the MSMS support and encourage hospitals to provide facilities for the diagnosis, treatment and rehabilitation of patients suffering from drug dependence when feasible.

• RESOLUTION 33

Mediation of Physician-Hospital Disputes
Arthur A. Ulmer, MD, Wayne County

HOUSE ACTION: Adopted As Amended, and Referred to AMA Delegates

Whereas, at present in many cases of dispute between hospital and physician, no impartial review or appeal procedure other than court or judicial process is available beyond the local hospital level to review or mediate a dispute, and

Whereas, judicial procedures often unnecessarily undermine public confidence in the health system and strain public relations, and

Whereas, because of the prolonged time and financial strain involved, judicial review of the parties in the dispute are often denied impartial review, and

Whereas, at present although it is understood that any board of review would have no legal status, it is felt that the moral suasion would be of benefit to all concerned; therefore be it

RESOLVED: That the AMA direct its constituent state and county Medical Societies, in cooperation with local hospital associations or groups to institute Boards of Arbitration to mediate hospital-physician disputes, and be it further

RESOLVED: That, in order to encourage participation in good faith by both parties, the AMA require this as a condition of membership for the physician and urge the Joint Commission on Accreditation of Hospitals to make this a bylaws requirement for hospital accreditation.

● RESOLUTION 34

Necessity of Postgraduate Study
John W. Moses, MD, Wayne County

HOUSE ACTION: Adopted

Whereas, the practice of medicine is a constantly changing and evolving profession requiring life-long study, and

Whereas, constant study is necessary to provide the highest quality of medical care possible; therefore be it

RESOLVED: That the MSMS endorse the principle of voluntary life-long postgraduate study for all physicians and continue to accelerate the development of programs and incentives for such study.

● RESOLUTION 35

Division of Legislative & Executive Functions
Keate T. McGunegle, MD, Sanilac County

HOUSE ACTION: Disapproved

Whereas, in most political associations there is a division of the legislative and executive functions and the same should be true of MSMS; therefore be it

RESOLVED: That no person may serve as both a member of the House and a member of The Council unless otherwise specified.

● RESOLUTION 36

Opposition to Anti-Substitution Repeal
Daniel J. Wilhelm, MD, St. Clair County

HOUSE ACTION: Adopted As Amended

Whereas, the American Pharmaceutical Association has voted to launch state-level campaigns to repeal statutes banning brand substitutions by pharmacists, and

Whereas, Michigan appears likely to be an early target in this effort, and

Whereas, lack of specific information concerning the relative merits of so-called equivalent drug products makes it difficult, if not impossible, for pharmacists to intelligently substitute or use other brands on a reasonable or rational basis, and

Whereas, substitution reduces the confidence physicians have developed in certain pharmaceutical manufacturers, in regards to continued purity of drugs, standards, research and ethics, and

Whereas, it is essential that the physician know what brand of drug product his patient is using for assurance that the same degree of absorption, blood level, duration of action, etc., will continue throughout the course of treatment, and

Whereas, legalized brand-switching, without the physician's knowledge or consent, could be hazardous to the patient and disruptive of the physician's treatment plan; therefore be it

RESOLVED: That this House of Delegates opposes and will resist all attempts to repeal the anti-substitution legislation, and be it further

RESOLVED: That a copy of this resolution be transmitted to the AMA, the Michigan Board of Pharmacy, the Michigan State Pharmaceutical Association, the State Executive Office, the State Legislature and all nationally recognized pharmaceutical associations.

● RESOLUTION 37

Reimbursement of Michigan Medical Service Board Members
James J. Lightbody, MD, Immediate Past President (for The Council)

HOUSE ACTION: Adopted

Whereas, the 1969 House of Delegates referred to The Council the question of reimbursing physician members of the Michigan Medical Service Board, as outlined in connection with Resolution 85 of the 1969 House of Delegates, and

Whereas, this matter was thoroughly reviewed by a committee of MSMS and The Council concurred in the committee's belief that 1) to do so would establish a dangerous precedent in the use of MSMS funds for per diem expenses of many other segments of the Society, and 2) available Society funds can better be spent on activities more closely related to the aims of organized medicine; therefore be it

RESOLVED: That the House of Delegates concur in the recommendation of The Council that MSMS not reimburse physician members of the Michigan Medical Service Board.

● RESOLUTION 38

Continuation of MD Volunteer Lobbying Program
James J. Lightbody, MD, Immediate Past President (for The Council)

HOUSE ACTION: Adopted As Amended

Whereas, the 1969 House of Delegates authorized the initiation of the MD volunteer lobbying program on a trial basis, and

Whereas, the MD volunteer lobbying program has enjoyed very favorable reception by the Michigan Legislature, the press, and other professional groups, and

Whereas, the program has met the goals established for it by impressing legislators with the interest of doctors, by providing legislators with medical information from the physicians themselves, and by acquainting physicians with the legislative process; therefore be it

RESOLVED: That the MSMS continue the MD volunteer lobbying program.

● RESOLUTION 39

Objection to Reimbursement of Chiropractors in Federally-Funded Health Programs
James J. Lightbody, MD, Immediate Past President (for The Council)

HOUSE ACTION: Approved

Whereas, it is the position of the medical profession that chiropractic is an unscientific cult whose practitioners lack the necessary training and background to diagnose and treat human disease, and

Whereas, the U.S. Department of Health, Education and Welfare in 1968, after an independent, unbiased study ordered by Congress, found that "Chiropractic theory and practice are not based upon the body of basic knowledge related to health, disease and health care that has been widely accepted by the scientific community," and

Whereas, "moreover, irrespective of its theory, the scope and quality of chiropractic education do not prepare the practitioner to make an adequate diagnosis and provide appropriate treatment," and

Whereas, chiropractic has never produced any scientific proof for its theories, although claiming competence to treat the broad spectrum of human disease, and

Whereas, the HEW Report to Congress received widespread support from nationally recognized consumer and health organizations, including the AFL-CIO, National Council of Senior Citizens, American Public Health Association, Association of American Medical Colleges and American Hospitals Association, and

Whereas, the medical profession has made repeated objections to appropriate federal, state and legislative officials that chiropractors are being reimbursed for their services under the State Medical Assistance Program (Medicaid) despite the fact that the HEW Task Force appointed by former Secretary Finch concluded in November, 1969, that payment for chiropractic services "is not effective use of Federal Medicaid funds;" therefore be it

RESOLVED: That the United States Congress and the Michigan Legislature be urged to forthrightly act to deny chiropractors any financial participation in any federally-funded health program, and be it further

RESOLVED: That copies of this resolution be transmitted to all members of the United States Congress and the Michigan Legislature, the State Executive Office and the Michigan Department of Licensing and Regulation.

● RESOLUTION 40

Printing of MSMS Directory of Members
James J. Lightbody, MD, Immediate Past President (for The Council)

HOUSE ACTION: Adopted As Amended

Whereas, the 1969 House of Delegates directed that the MSMS Directory of Members be printed every other year instead of annually, to save an estimated $6,000, the printing cost for previous annual directory issues, and

Whereas, the MSMS printer has provided an estimate that a directory could be produced for $3,240 (about half the previous cost) by using a photo-offset process from the IBM computer print-out instead of having the names set in type as in the past, and

Whereas, the value of a Directory printed every other year is greatly diminished because of the many address and name changes each year — for example, there are 2,000 to 4,000 changes in address each year, 250 new members each year, 100 who move out of the state, and 100 deaths each year, and

Whereas, a proposed 1971 Directory could be issued in December, 1970, at a cost of $3,240; therefore be it

RESOLVED: That an annual directory be published with listing by component societies with a city-county cross indexing.

● RESOLUTION 41

Councilor for Oakland County
Arnold L. Brown, MD, Oakland County

HOUSE ACTION: Disapproved

Whereas, Article X, Section 1 of the Constitution of the MSMS authorizes one Councilor from each Councilor District or one Councilor for each ten delegates when the number of delegates from a district exceeds ten, and

Whereas, Oakland County now has fourteen authorized delegates, and

Whereas, Oakland County is included in the Fifteenth District with Macomb County in Chapter 10, Section 9 of the MSMS By-Laws; therefore be it

RESOLVED: That Chapter 10, Section 9 of the MSMS By-Laws be amended to place Oakland County in a Councilor District of its own, thereby providing one Councilor from Oakland County.

● RESOLUTION 42

Extra Meeting of MSMS House of Delegates
Harold A. Furlong, MD, Oakland County

HOUSE ACTION: Disapproved

Whereas, the sessions of the AMA are held in June and November, and

Whereas, the Annual Sesison of the MSMS is held in September, and

Whereas, this is a lapse of one year between the Annual Meeting of the MSMS, the Annual Session of the AMA and six months between the Annual MSMS Meeting and the Clinical Sessions of AMA, and

Whereas, the delegates to AMA must wait a year to inform and discuss the House of Delegates of MSMS of the actions of the House of Delegates of AMA, and

Whereas, the delegates of MSMS to the AMA would be much better prepared to express the wishes of the House of Delegates of MSMS if there were a meeting of MSMS prior to the annual AMA session in June and could more adequately report the actions of the AMA House of Delegates to the House of Delegates of MSMS at the Annual Session of MSMS in September; therefore be it

RESOLVED: That an extra meeting of the MSMS House of Delegates be held in April or May prior to the Annual Meeting of the House of Delegates of the AMA, and the usual MSMS Annual Session be held as now in September.

● RESOLUTION 43

Drug Control
Frederick S. Gillett, MD, Kent County

HOUSE ACTION: Substitute Resolution Adopted for Resolutions 25, 43 & 75—See Resolution 25

● RESOLUTION 44

Malpractice and the Contingency Fee
Jack Hoogerhyde, MD, Kent County

HOUSE ACTION: Referred to The Council for Study

Whereas, the increase in malpractice suits against physicians has reached an alarming proportion, and

Whereas, the size of legal fees is contingent on the amount of the damages awarded in a suit, thus encouraging attorneys to bring malpractice action against physicians with demands for ever increasing amounts, and

Whereas, the malpractice insurance rates have risen to prohibitive heights, and

Whereas, many unnecessary laboratory and x-ray studies are now being ordered by physicians as a precautionary measure against potential law suits, and

Whereas, these increased costs are reflected in higher medical fees, which must be borne by the consumer (patient), and

Whereas, the contingency fee principle is unethical and illegal in other countries; e.g. Canada, where malpractice suits against physicians are almost non-existent, and

Whereas, the abolishment of the contingency fee would very materially reduce the number of malpractice suits brought against physicians; therefore be it

RESOLVED: That the MSMS, through its Legal Affairs Committee, begin early discussion with the Michigan State Bar Association, in an attempt to resolve the creeping menace of unreasonable malpractice suits, and be it further

RESOLVED: That top priority be given to the Legislative Committee of the MSMS to set in motion the legal machinery necessary to bring about the abolition of the contingency fee, and be it further

RESOLVED: That our endeavors to abolish the contingency fee be widely publicized to our friends in other areas, such as the Farm Bureau, the news media, radio and television, labor unions, etc., and be it further

RESOLVED: That an Adjudication Commission be established to consider all claims for possible malpractice action.

● RESOLUTION 45

Rehabilitative Care
Harvey M. Andre, MD, Kent County

HOUSE ACTION: Adopted As Amended

Whereas, in the provision of adequate rehabilitative care in acute hospitals and extended care facilities there have been many problems arising concerning:

1. The responsibility for determining which patients need and shall receive rehabilitative care as determined by physicians versus lay personnel.

2. The establishment of proper guidelines for rehabilitative care of suitable patients.

3. The remuneration of hospitals and extended care facilities for such necessary services provided.

4. The remuneration of physicians ordering or providing such necessary services or care, and

Whereas, these practices must be established within the economic feasibility for providing such services, and

Whereas, differentiation must be made between acute rehabilitative care, intermediate rehabilitative care, and long-term rehabilitative care; therefore be it

RESOLVED: That The Council utilize the Socio-Economic and Hospital Relations Committees to aid the Rehabilitation Committee in forming guidelines for rehabilitative care in acute hospitals or extended care facilities and to arrange an acceptable remuneration to both the institution providing and the physician ordering such care.

● RESOLUTION 46

Establishment of Socio-Economic Department
William Haeck, MD, Kent County

HOUSE ACTION: Substitute Resolution Adopted for Resolutions 10, 46, 47, 70 and 90—See Resolution 10

● RESOLUTION 47

Establishment of Socio Economic Department
Kornelius Van Goor, MD, Kent County

HOUSE ACTION: Substitute Resolution Adopted for Resolutions 10, 46, 47, 70, 90—See Resolution 10

● RESOLUTION 48

Drug Intoxication and/or Addiction: A Disease
Victor A. Notier, MD, Kent County

HOUSE ACTION: Adopted As Amended

Whereas, drug intoxication and/or addiction has become so widespread that they now constitute a national menace, and

Whereas, the increasing numbers of users of drugs are being treated in acute care hospitals, and

Whereas, the liability for such care is denied to the hospitals and other providers by insurance carriers, Medicaid, other agencies, etc., and

Whereas, if drug intoxication and/or addiction were designated, specifically, a disease, similar to alcoholism, the liability for such care would be provided; therefore be it

RESOLVED: That MSMS take such action through its Legal Affairs Committee to declare that drug intoxication and addiction constitute a disease and should be a Medicaid benefit, and be it further

RESOLVED: That a copy of this resolution be sent to the proper State and Federal agencies.

● RESOLUTION 49

Uniform Billing Practices
C. A. Vandervelde, MD, Muskegon County

HOUSE ACTION: Disapproved

Whereas, it is expensive, impractical and inefficient for physicians to be required to fill out multiple types of forms for either patient or doctor third-party reimbursement for medical services, and

Whereas, a simple itemized physician statement for rendered services can be complete, sufficient, and uniform for any reimbursement and billing requirements, and

Whereas, manipulation and use of the offered data has as as many variations as there are payors, which variations are properly the responsibility of each payor and cannot be considered the responsibility of the physician in any way; therefore be it

RESOLVED: That the MSMS designate a standardized statement form for patient and third-party payor billing, and further be it

RESOLVED: That the MSMS defend the right of any or all of its members, individually or as a society, to use exclusively and expect payment on such standardized forms in all billing procedures for medical professional services to individuals, insurance companies or governmental agencies and programs.

● RESOLUTION 50

Medical School Departments of General Practice
C. A. Vandervelde, MD, Muskegon County

HOUSE ACTION: Substitute Resolution Adopted for Resolutions 7, 13, 29, 50, 85, 96—See Resolution 7

● RESOLUTION 51

Formation of the Michigan State Hospital Staff Association
C. A. Vandervelde, MD, Muskegon County

HOUSE ACTION: Referred to Hospital Relations Committee

Whereas, the physicians of Michigan must maintain their strong and informed influence in the medical care of hospital patients in the State of Michigan, and

Whereas, there are very influential hospital associations of practical nurses, registered nurses, pharmacists, and administrators, and

Whereas, there is a growing tendency toward usurpation of the hospital role of the physician by administrative, social service, paramedical and governmental activities often without consultation with physicians or even rudimentary knowledge of the impact of such activities on physicians, and

Whereas, there is now no organization of physicians oriented 1) to the problems of hospital care; 2) to providing advisory services to staff groups, or 3) to permit function of a strong active group to assist medical staffs of hospitals in their efforts to maintain high quality patient care; therefore be it

RESOLVED: That the MSMS establish a semi-autonomous association to be called the Michigan State Hospital Staff Association whose governing body is made up of representatives from every organized hospital staff in the State of Michigan and supported by dues payable to the association assessed hospital staffs on a per capita basis, and further be it

RESOLVED: That particular efforts should be made to include community hospital staff members, to provide a monthly publication of pertinent information to the membership, and to establish a central clearing house for useful information and data relating to hospital problems as they concern patient care and the physician's role.

● RESOLUTION 52

Establishment of Priorities for the Expenditure of MSMS Funds
C. A. Vandervelde, MD, Muskegon County

HOUSE ACTION: Disapproved

Whereas, there are valid demands for significant funding of vital new MSMS programs, and

Whereas, dues monies are held dear to all MSMS members, particularly when their significant and productive use appears to diminish a little more each year; therefore be it

RESOLVED: That the MSMS Council establish an ad hoc committee

1. to scrutinize the purposes for which all funds are expended

2. to analyze each in terms of relative importance to the newer needs of the MSMS as well as in terms of one another

3. to study possible savings to be found through consolidation of similar activities and staffs, and

4. to report their findings and recommendations to the membership of the MSMS six weeks prior to the next annual meeting of the 1971 House of Delegates, and further be it

RESOLVED: That the 1971 House of Delegates take any necessary definitive action for immediate implementation of favored portions of the report during the regular business of their annual meeting or any special meeting called for that purpose.

● RESOLUTION 53

Responsibility of Physicians Accepting Third Party Payments
H. V. Sanden, MD, Muskegon County

HOUSE ACTION: Disapproved

Whereas, any payor, public or private, individual or organized group, has a right to know what he is paying for; therefore be it

RESOLVED: That the MSMS recommend to its membership that physicians voluntarily accepting third party payments make available for examination to the payors specific records relating to any of the specific services for which their payment is made, provided that significant expenses incurred by such examination be borne by the examinor, that a fair reimbursement be determined for any reduction in practice time available to the physician, and that patient consent has been obtained.

● RESOLUTION 54

The Patient's Right to Choose Manner of Payment
H. V. Sanden, MD, Muskegon County

HOUSE ACTION: Disapproved

Whereas, payment for medical services is basically a matter of the transfer of money to the provider of those services, and

Whereas, circumstances for the most effective means of causing this transfer are highly variable, and

Whereas, the charge for medical services is not necessarily related to the amount of third-party payment; therefore be it

RESOLVED: That the MSMS espouse and legally support the principle that the distribution of any and all third-party payments for itemized medical services be solely at the discretion of the person receiving the services or his legal representative and that in the matter of third-party payors all payment benefits be assignable by the patient without limitation or exception.

● RESOLUTION 55

Dissolution of the Corporate Relationship of Michigan State Medical Society to Blue Shield
H. V. Sanden, MD, Muskegon County

HOUSE ACTION: Disapproved

Whereas, the MSMS has had ineffective representation on the Blue Shield Board of Directors, and

Whereas, there is no prospect for effective representation of Michigan physicians on the Blue Shield Board of Directors in the traditional manner or modifications thereof; therefore be it

RESOLVED: That the Speaker of the House of Delegates immediately appoint an ad hoc committee from among the 1970 Delegates to formulate and present a motion to dissolve all corporate relationship between Blue Shield and MSMS under new business to the meeting of the Blue Shield corporation on September 22, 1970.

● RESOLUTION 56

Disposal of Disposables
H. V. Sanden, MD, Muskegon County

HOUSE ACTION: Adopted As Amended

Whereas, there is a marked and continuing increase in hospital and office use of disposable equipment, and

Whereas, the disposal of disposables presents a growing economic and ecological threat; therefore be it

RESOLVED: That all users of disposable equipment, especially hospitals, be urged to reconsider their current use of disposables and any extension of their use, and further be it

RESOLVED: That the supplier be required to accept return of such items for re-use or disposal, and be it further

RESOLVED: That The Council refer this to its Public Health Committee for consideration and implementation.

● RESOLUTION 57

Third-Party Default by Delay of Payment or Arbitrary Reduction of Fees
H. V. Sanden, MD, Muskegon County

HOUSE ACTION: Disapproved

Whereas, third-party payors have demonstrated a propensity to withhold or arbitrarily reduce payments for services by physicians; therefore be it

RESOLVED: That the MSMS unequivocally support, by word and deed, physicians who wish to consider either failure to pay reasonable fees within 120 days, or the arbitrary reduction of previously paid fee levels, as a breach of contract which releases the physician from any previous agreement, express or implied, to accept such third-party payment, and further be it

RESOLVED: That in the event of a widespread involvement of MSMS members in such situations with one or more outside payors exclusive of private individuals, the MSMS will file a class action suit in the name of Michigan physicians to rectify the matter through the appropriate courts.

• RESOLUTION 58

To Produce More Physicians
H. C. Tellman, MD, Muskegon County

HOUSE ACTION: Substitute Resolution Adopted for Resolutions 7, 13, 29, 50, 85, 96—See Resolution 7

• RESOLUTION 59

Defense of Michigan Doctors
H. C. Tellman, MD, Muskegon County

HOUSE ACTION: Disapproved

Whereas, there are extant many letters from third-party payors to patients implying the possibility of unreasonable doctor behavior, and

Whereas, there are many unwarranted and misleading statements published and information promulgated concerning the practice and pratitioners of medicine in Michigan, and

Whereas, there has been no clear voice speaking on the behalf of the doctors of Michigan, individually or collectively, and

Whereas, there has been no effort to legally direct and support physicians of Michigan in the quest for public hearing and justice; therefore be it

RESOLVED: That The Council of MSMS develop and fund a program to make possible knowledgeable and ready response against misleading or false information concerning the doctors of Michigan and to provide legal defense for the practice and practitioners of medicine in Michigan, and further be it

RESOLVED: That The Council of MSMS implement such a program prior to January 1, 1971.

• RESOLUTION 60

Dissatisfaction with the Operational Effectiveness of Michigan State Medical Society
H. C. Tellman, MD, Muskegon County

HOUSE ACTION: No Action

Whereas, there is every indication of thankless, sincere and commendable effort by councilors and other high officers of MSMS, and

Whereas, the MSMS has accomplished many good things over the years, and

Whereas, there seems to be a creeping paralysis in the timely, effective function of the MSMS in areas where there have been specific directives, in areas requiring innovative thought and action, in the growing elapsed time between concept and accomplishment and in the area of good new ideas which are still-born, and

Whereas, we are at a time when organizational strength and effectiveness is at a premium and these attributes of MSMS seem to be waning; therefore be it

RESOLVED: That the MSMS Council take all necessary steps

1. to achieve a reorganization which will free The Council from deliberation of minutiae, inconsequentials, and routine
2. to relieve The Council of dependence on non-functioning or poorly attended committees
3. to relieve The Council from consideration of or preoccupation with ritual
4. to cull outmoded committees
5. to cull non-performing or uninspired chairmen and committee members
6. to develop a dynamic and demanding program of leadership development
7. to become a responsible and responsive executive body which demands performance of its committees and is productive of importantly meaningful acts and directives.

• RESOLUTION 61

MSMS Relationship with Outside Groups, Associations, Corporations, Governmental Units or Other
H. C. Tellman, MD, Muskegon County

HOUSE ACTION: No Action

Whereas, no relationship is satisfactory if it is unequally obligatory or demanding for one of the parties, and

Whereas, the MSMS has become involved in certain relationships which have created just such one-sided situations, and

Whereas, there will be increasing opportunities for involvement with parties outside of the MSMS; therefore be it

RESOLVED: That any relationship between MSMS and an outside individual, group, association, corporation, governmental unit, or other

1. be subject to annual review by the House of Delegates of the MSMS acting as that body
2. be subject to a detailed, legal contractual expression in writing, and
3. be approved by The Council of the MSMS subject to approval of their action by a majority vote at the next annual meeting of the House of Delegates or at a special meeting called for such purpose, and further be it

RESOLVED: That any such relationship require a mechanism, when necessary, for hearing and binding resolution of grievances of any of the parties, and further be it

RESOLVED: That individual members of MSMS be considered as parties in any such relationship.

• RESOLUTION 62

National Health Plans
John H. van de Leuv, MD, Oakland County

HOUSE ACTION: Disapproved

Whereas, various agencies, including legislators have introduced or are planning to introduce proposals for nationwide health insurance, and

Whereas, each and every one of these plans deeply involve the licensed physicians, i.e., private practitioners, in the United States, and

Whereas, the practice of medicine, its remuneration and method of delivery will be involved, and

Whereas, the physicians practicing private medicine must have the right to determine their method of participation; therefore be it

RESOLVED: That the MSMS hereby declare that it will not under any circumstances become part and parcel or in any way participate in any program of national health insurance that is not completely endorsed by representatives of all practicing physicians in the United States, and be it further

RESOLVED: That the MSMS urge physicians in all states of the United States to follow its example.

● RESOLUTION 63

Composition of State Comprehensive Health Planning Advisory Council

D. Bonta Hiscoe, MD, Ingham County

HOUSE ACTION: Adopted

Whereas, only three practicing physicians serve on the State Advisory Council, and

Whereas, it has been proposed to increase membership on the State Advisory Council by including the members of the State Health Planning Commission, and

Whereas, it has been further proposed to add one consumer representative from each organized areawide planning council on the State Advisory Council, and

Whereas, there has been no suggestion that provider representation be comparably increased on the State Advisory Council, and

Whereas, enlarging the State Advisory Council in this manner without considering the important role and participation of the provider is discriminatory and would further dilute the unique expertise which only the medical profession can provide; therefore be it

RESOLVED: That this House of Delegates believes that fairness requires that a comparable number of providers, preferably practicing physicians, be added to the State Advisory Council for each additional consumer representative, and be it further

RESOLVED: That a copy of this Resolution be directed to the Office of the Governor and the Chairman of the State Advisory Council.

● RESOLUTION 64

Commendation to Michigan Comprehensive Health Planning Advisory Council

D. Bonta Hiscoe, MD, Ingham County

HOUSE ACTION: Adopted

Whereas, the Comprehensive Health Planning Task Force on Health Manpower reviewed the conclusion of the Report of the Citizens Committee on Education for Health Care that "it is clear that extension or expansion of the practice of chiropractic in the State of Michigan would not be in the best interest of the health and welfare of the citizens of the State," and

Whereas, the State Comprehensive Health Planning Advisory Council adopted a Task Force resolution opposing passage of Michigan Senate Bill 1756, which would cover chiropractic services under Blue Shield; therefore be it

RESOLVED: That this House of Delegates commend the State Comprehensive Health Planning Advisory Council for its forthright position, and be it further

RESOLVED: That a copy of this Resolution be transmitted to the State Executive Office and the Chairman of the State Advisory Council.

● RESOLUTION 65

Increase State Funds for Alcohol Programs

William Haeck, MD, Kent County

HOUSE ACTION: Adopted As Amended

Whereas, the State of Michigan is in the business of selling liquor, and

Whereas, the State of Michigan realizes over one hundred million dollars annually from the sale of alcohol, and

Whereas, the Michigan Legislature has appropriated only $400,000 for alcohol programs in Michigan, this amount to be divided among the twelve approved alcohol programs in the state, and

Whereas, this $400,000 is a grossly inadequate amount to finance these alcohol programs; therefore be it

RESOLVED: That MSMS through its Legal Affairs Committee request the Legislature to approve greater and more adequate amounts of money for approved alcohol programs for medical care and rehabilitation.

● RESOLUTION 66

Abolishment of Regional Screen Variation in Reimbursement by Blue Shield

Donald N. Fitch, MD, Delta-Schoolcraft County

HOUSE ACTION: Referred to Committee on Medical Socio-Economics for study

Whereas, the present concept of Blue Shield reimbursement involves regional variations allegedly related to variations in local economic levels and local charges of record, and

Whereas, these various regional screens supposedly serve to reflect local or regional economic levels (i.e. cost of living), and

Whereas, all factors considered, it is debatable if there is any significant difference in the actual cost of living from one end of our State of Michigan to the other, and

Whereas, it has been repeatedly seen that lower reimbursement screens have a very negative effect in attracting physicians, either of specialty or family practice orientation, to the outlying areas of more desperate need, in spite of the fact that we are seeking means to otherwise attract physicians to these areas, and

Whereas, it seems and would appear that the regional variations in insurance premium for the consumer does not vary in degree to the variation of reimbursement; therefore be it

RESOLVED: That MSMS request that Michigan Blue Shield henceforth institute a statewide uniform fee schedule or screen based only on variation in individual experience.

● RESOLUTION 67

Compensation for Medical Service in Extended Care Facilities

Henry A. Scovill, MD, Washtenaw County

HOUSE ACTION: No Action

Whereas, there are large numbers of patients being cared for by private physicians in extended care facilities under Medicare and Medicaid, and

Whereas, this year compensation allowed under these plans has arbitrarily been cut to 25% of that formerly paid and far below actual cost of providing service, and

Whereas, there is increasing harassment with repetitious forms and paper work causing ever increasing costs for office management which is entirely uncompensated, and

Whereas, Blue Cross-Blue Shield offers little hope of relieving this intolerable situation; therefore be it

RESOLVED: That the MSMS exert all possible pressure and influence with the proper authorities to insure adequate and equitable compensation for services rendered patients in extended care facilities.

● RESOLUTION 68

Bylaw Amendment for Membership Transfers
James Danforth, Jr., MD, Wayne County

HOUSE ACTION: Disapproved

Whereas, the County Medical Society must have a complete report on a physician who is applying for membership in order to evaluate equitably his qualifications for membership, and

Whereas, the MSMS Bylaws require only that the physicians applying for a transfer of his membership present a certificate of good standing from his former medical society, therefore be it

RESOLVED: That Chaper 4, Section 1, of the Bylaws of the MSMS be amended as follows:

Revise the second sentence by adding the words "and membership record which shall include any complaints received by the Mediation and Ethics Committee and their findings" and by substituting "this information" for "certification of good standing".

As amended this sentence will read:

"Thereupon, the secretary of the society to which application is made shall request certification of standing AND MEMBERSHIP RECORD WHICH SHALL INCLUDE ANY COMPLAINTS RECEIVED BY THE MEDIATION AND ETHICS COMMITTEES AND THEIR FINDINGS from the Society from which the member desires to transfer and upon receipt of such request the secretary of the latter Society shall supply THIS INFORMATION, provided the following requirements have been met. . . ."

● RESOLUTION 69

Guidelines for Funds Derived from the Supervised Care of Staff Patients
Sidney Adler, MD, Wayne County

HOUSE ACTION: Adopted As Amended

Whereas, Medical staff funds have grown in scope and number, and

Whereas, such funds must be consistent with the law and the Principles of Medical Ethics of the AMA, and

Whereas, it is the responsibility of the MSMS and its constituent societies to provide guidance to its members on the proper implementation of AMA policy; therefore be it

RESOLVED: That the MSMS adopt the following statement of policy;

GUIDELINES FOR MEDICAL STAFF FUNDS

1. Participation in such Funds shall be completely voluntary.

2. The Board of Directors, Trustees, or other governing body of the Fund shall be limited solely to physicians who are members of the Fund.

3. The Constitution, By-laws or other governing rules of the Fund shall provide that all elections and votes on major decisions by the membership shall be by secret written ballot.

and be it further

RESOLVED: That copies of these Guidelines be forwarded to the Chiefs of Staff of all Michigan hospitals and publicized to the membership through the Journal of the MSMS.

● RESOLUTION 70

Socio-Economic Department
Frank Walker, MD, Wayne County

HOUSE ACTION: Substitute Resolution Adopted for Resolutions 10, 46, 47, 70, 90—See Resolution 10

● RESOLUTION 71

Chiropractic
F. P. Rhoades, MD, Wayne County

HOUSE ACTION: Adopted As Amended

Whereas, it is the position of the AMA that chiropractic is an unscientific cult whose practitioners lack the necessary training and background to diagnose and treat human disease, and

Whereas, the United States Department of Health, Education, and Welfare, after an independent, unbiased study ordered by Congress, has found that "chiropractic theory and practice are not based upon the body of basic knowledge related to health, disease, and health care that has been widely accepted by the scientific community. Moreover, irrespective of its theory the scope and quality of chiropractic education do not prepare the practitioner to make an adequate diagnosis and provide appropriate treatment"; therefore be it

RESOLVED: That the House of Delegates of the MSMS at its annual session in September 1970 call on each county medical society to take whatever steps are necessary to inform state legislators of the H.E.W. evaluation of the practice of chiropractic.

● RESOLUTION 72

Disassociation of MSMS from Michigan Blue Shield
Lewis E. Simoni, MD, Genesee County

HOUSE ACTION: Disapproved

Whereas, the association which exists between MSMS and Michigan Blue Shield does not clearly identify in the eyes of the public which organization is fiscally responsible for the action of Michigan Blue Shield, and

Whereas, to this date the physicians of Michigan have suffered unwarranted adverse publicity as the result of fiscal irresponsibility, despite their inability to control administrative decisions of Michigan Blue Shield, therefore be it

RESOLVED: That the 1970 MSMS House of Delegates clearly state their desire to totally disassociate forthwith from the corporate body of Michigan Blue Shield.

● RESOLUTION 73

Civil Prosecution of Individuals Associated with Possession or Transmission of Narcotics and Dangerous Drugs
Richard R. Galpin, MD, Oakland County
Richard McCaughey, MD, Oakland County

HOUSE ACTION: Adopted As Amended

Whereas, the drug abuse problem is becoming more and more an acute problem within the state amongst teenagers and young adults, and

Whereas, it is becoming increasingly evident that use of said drugs is being accomplished within the confines of residences of said users with the knowledge and condonation of the parents or home owners of said residence, implied or actual consent, and

Whereas, there is presently no offense committed or penalty imposed for the knowledge or condonation of the use of said drugs within the State of Michigan, and

Whereas, new legislative controls are urgently indicated in order to facilitate more adequate control of this problem, and

Whereas, legislation is already in existence in the State of Michigan covering the making available of alcoholic beverages to minors (Dramshop Act) and for the purpose of this resolution the term "dangerous drugs" shall imply, barbiturates, hallucinogens, amphetamines, and any other such medication being used without proper prescription or intent; now therefore be it

RESOLVED: That The Council direct the Legislative Committee of the MSMS to petition the State Legislature to enact a bill making it an offense to allow and/or condone the use of narcotics and dangerous drugs within a residence or other properties with the actual or implied knowledge of the parent, homeowner, resident or other owner of said property and that the foregoing offense should be subject to civil prosecution with appropriate penalties; in addition to penalties already provided by existing criminal statutes.

● RESOLUTION 74

Privilege of Minors to Give
Consent for Examination
Richard R. Galpin, MD, Oakland County

HOUSE ACTION—Adopted As Amended

Whereas, many minors are reluctant to seek treatment for drug involvement and suspected pregnancy because they know their parents should be notified to gain consent for treatment, and

Whereas, these two groups constitute a serious problem both medically and socially in our community, and

Whereas, a similar resolution was submitted in 1968 [No. 33] with respect to treatment of venereal disease; therefore, be it

RESOLVED: That The Council direct its Legislative Policy Committee to recommend to the State Legislature to enact suitable legislation to allow minors (ages 16 to 21) to give their own consent for examination (including pelvic examination) sufficient to permit adequate diagnosis and to initiate appropriate treatment procedures.

● RESOLUTION 75

Support of the Governor's Proposal
for Control of Drug Abuse
Benjamin Jeffries, MD, Wayne County

HOUSE ACTION: Substitute Resolution Adopted for Resolutions 25, 43 and 75—See Resolution 25

● RESOLUTION 76

Business Relationships Between Michigan Medical
Service and Professional Corporations
Frank H. Power, MD, Grand Traverse-
Leelanau-Benzie County

HOUSE ACTION: Adopted

Whereas, an increasing number of physicians are practicing in groups as professional corporations, and

Whereas, the courts and the I.R.S. have held that all physicians in these corporate groups are employees of the corporation, and that, if corporate status is to be respected by the I.R.S., charges for professional services *must be made by and in the name* of the professional corporation, and

Whereas, being able to submit reports and charges in the name of the corporation instead of the individual physician is more efficient and less expensive, resulting in lower cost of services, and

Whereas, Michigan Medical Service has been requested, and refuses, to accept reports of professional services in the name of these corporations *only;* but insists upon dealing with and crediting payments to the individual physician and using their individual I.R.S. identification numbers instead of that of the corporation, and

Whereas, the MMS administration's alleged reason for this is based on ancient decision to that effect by the MMS Board of Directors; therefore be it

RESOLVED: That the Director of the MSMS be directed to call this matter directly to the attention of the Chairman of the Board of MMS with the strong request that the present policy be promptly reviewed by his board and changed to provide for proper conduct of business relationships between MMS and professional corporations, in accordance with usual, customary, and legal business practices between duly constituted corporations, and specifically to direct the MMS administration to accept billings for professional services provided by professional corporations upon submission of a report approved by the authorized representative of that professional corporation.

● RESOLUTION 77

Association Between MSMS and
Michigan Blue Shield
Frank H. Power, MD, Grand Traverse-
Leelanau-Benzie County

HOUSE ACTION: Disapproved

Whereas, the original relationship between MSMS and Michigan Medical Service has long ago accomplished its intended purposes, and

Whereas, many members of MSMS now find that the continuing official relationship between MSMS and Michigan Medical Service interferes with the physician-patient relationship in the everyday practice of medicine, and

Whereas, Michigan Medical Service brings discredit upon the medical profession each time it requests a rate increase, and

Whereas, Michigan Medical Service has spawned a huge bureaucracy whose policies have not been and are not now responsive to the expressed needs of Michigan physicians; therefore be it

RESOLVED: That the 1970 House of Delegates of MSMS strongly urge its delegates when sitting as members of the Corporate Body of Michigan Medical Service to take the following two steps.

1. Reject the plan of reorganization recommended by the Michigan Medical Service Board of Directors, and

2. Instruct that Board of Directors to take all necessary steps to call a special meeting of the Corporate Body at the earliest possible time for the purpose of accomplishing complete official separation between Michigan Medical Service and MSMS.

● RESOLUTION 78

Proposed Michigan Blue Shield Amendment
to its Articles of Incorporation
John Quin, MD, Genesee

HOUSE ACTION: Disapproved

Whereas, Michigan Blue Shield has proposed amending its Articles of Incorporation relative to medical doctor's membership therein, and

Whereas, said amendment would neither foster the image of the physician in the eyes of the public nor clearly define the position of the medical doctor in the now defunct and bankrupt Michigan Blue Shield, and

Whereas, the goals of Michigan Medical Service do not remotely include the interests of the medical doctors of Michigan; therefore be it

RESOLVED: That the MSMS House of Delegates be and are opposed to said amendment and are in favor of complete and total disassociation with Michigan Blue Shield.

● RESOLUTION 79

Relationship of Blue Shield and MSMS
F. Patrick McQuillan, MD, Jackson County

HOUSE ACTION: Disapproved

Whereas, the actions of the Blue Shield Board have not always represented the thinking of the majority of the members of MSMS in the past, and

Whereas, there is little to suggest that their actions in the future will reflect the will of the majority of physicians of MSMS, and

Whereas, the Jackson County Medical Society has for the third consecutive year voted unanimously to correct this situation, therefore be it

RESOLVED: That the House of Delegates initiate immediately the legal requirements necessary to sever the relationship of MSMS and the Michigan Blue Shield completely.

● RESOLUTION 80

Physician Staffing of Blood Donor Clinics
Charles A. Thompson, MD, Genesee County

HOUSE ACTION: Adopted

Whereas, there is now in effect a regulation issued by the Michigan Department of Health, which requires the presence of a physician at Red Cross Blood Donor Clinics, and

Whereas, because of the shortage of physicians to deliver medical care to the residents of Michigan, it has become increasingly difficult to arrange for attendance of physicians at blood donor clinics, and

Whereas, the American Red Cross has recognized this problem and recommends only that properly trained nurses and medical assistants be present at blood donor clinics and that a qualified physician be "on call" should an emergency arise, therefore be it

RESOLVED: That the MSMS request the Director of the Michigan Department of Health to immediately rescind and/or modify the present regulation to conform with the recommendations of the American Red Cross, so that a physician need not be actually present at blood donor clinics but may be "on call" to direct the management of such emergencies as might arise, and be it further

RESOLVED: That MSMS instruct its component societies to assist the American Red Cross in the training of paramedical personnel to staff the blood donor clinics, and to arrange with physicians, ambulance services, and hospital emergency rooms to care for the rare emergency occuring in the conduct of blood donor clinics which does not respond to first aid treatment at the clinic.

● RESOLUTION 81

Preparation of Contractual Fee Schedule for Governmental Agencies
Richard C. Deming, MD, Jackson County

HOUSE ACTION: Adopted As Amended

Whereas, it has become apparent that governmental health agencies may request fixed fee schedules, and

Whereas, no contractual fee schedule has been prepared by the MSMS, and

Whereas, such a schedule may be required in the future, therefore be it

RESOLVED: That MSMS, through appropriate mechanism, develop a fee schedule satisfactory to the medical profession for all professional contractual relationship with governmental agencies wherever or whenever this is necessary.

● RESOLUTION 82

Payment of Physician Charges by Credit Cards
Robert M. Stow, MD, Ingham County

HOUSE ACTION: Adopted As Amended

Whereas, credit cards are approved methods of payments for goods and services throughout the country, and

Whereas, 23 state medical societies have approved such method of payment, and

Whereas, Arizona Medical Society has given approval to bank advertising that many physician bills can be paid using their "bank cards" providing no names of physicians are used; therefore be it

RESOLVED: That the Judicial Commission be requested to consider the ethical aspects of these matters and render its opinion.

● RESOLUTION 83

Repeal of Basic Science Act
Robert M. Stow, MD, Ingham County

HOUSE ACTION: Adopted

Whereas, doctors of medicine, doctors of osteophathy and chiropractors, who are graduates of medical schools in the United States, are already exempt from taking the basic science examination, and

Whereas, the only physicians required to take the basic science examination are graduates of foreign medical schools, and

Whereas, these physicians will be examined by their licensing boards, and

Whereas, many well-qualified graduates of foreign medical schools are now practicing in our communities; therefore be it

RESOLVED: That the Basic Science Act be repealed in its entirety.

● RESOLUTION 84

Pilot Program of Baccalaureate Study Physician Assistant
W. K. Locklin, MD, Kalamazoo

HOUSE ACTION: Adopted As Amended

Whereas, the Physician Assistant Subcommittee of the Education Liaison Committee has completed the feasibility study, and has recommended adoption of the program submitted by William G. Birch, MD, to the House of Delegates at its session in 1965, and

Whereas, The Council of MSMS has invited Western Michigan University to undertake a pilot program of Baccalaureate study for the education of this medical professional, and

Whereas, Western Michigan University has agreed to undertake this pioneering medical program, and

Whereas, the House of Delegates has annually encouraged the continuing work toward this goal; therefore be it

RESOLVED: That the House of Delegates unanimously endorse this pilot program of physician assistants of Western Michigan University, offer continuing support, and hereby thank all of those who are and continue to be involved in its further development.

● RESOLUTION 85

Establishment of a Family Practice Department
C. W. Oakes, MD, Huron County

HOUSE ACTION: Substitute Resolution Adopted for Resolutions 7, 13, 29, 50, 85, and 96—See Resolution 7

● RESOLUTION 86

Conference on Maternal and Perinatal Health
Clark Smith, MD, Hillsdale County

HOUSE ACTION: Withdrawn

● RESOLUTION 87

Smoking During Meetings of House of Delegates
Clark Smith, MD, Hillsdale County

HOUSE ACTION: Approved

Whereas, smoking is unhealthy, and

Whereas, the MSMS should take the lead in promoting the good health of the public in general, and in particular, of its members; therefore be it

RESOLVED: That the House of Delegates should prohibit smoking during all of its meetings.

● RESOLUTION 88

Michigan Medical Service Board of Directors
Clark Smith, MD, Hillsdale County

HOUSE ACTION: Disapproved

Whereas, all of the original incorporators of Michigan Medical Service were Doctors of Medicine, and

Whereas, Section 8 of the Enabling Act of 1939 provides that ". . . a majority of the directors (of a non-profit medical care corporation) shall be AT ALL TIMES PERSONS APPROVED BY THE OFFICERS OF THE MEDICAL PROFESSION duly organized to promote state-wide the science and art of medicine . . . ," and

Whereas, Article Four of the Articles of Incorporation of MMS states the membership of the corporation shall be the members of the House of Delegates of the MSMS and that not more than 10% of the membership shall be composed of persons not practicing a healing art; and Section Five of the same Articles of Incorporation requires 60% of the Board of Directors to be physicians as defined in the subscriber contract, and

Whereas, the physicians who are elected to the Board of Directors of Michigan Medical Service should represent the physicians and patients and not the political or social reform or other interests of other special interest groups, and

Whereas, the Board of Directors of Michigan Medical Service is seeking changes in its own composition of such a nature as to reduce MD representation on the Board from 60% to 33%, and to reduce MD representation in corporate body from "at least 90%" to 33%, and

Whereas, according to Article II, Section 4 of the MMS Bylaws, "The Board of Directors shall have supervision and control of the business, property, affairs and management of the Corporation," and

Whereas, the current physician-members of the Board of Directors have repeatedly shown an unwillingness or inability to represent the interests of physicians and patients as indicated by the results of their supervision and control of the business, property, affairs and management of Michigan Medical Service; therefore be it

RESOLVED: That the MSMS House of Delegates, acting as the corporate body, institute immediate action to recall and remove from office the entire Board of Directors of Michigan Medical Service, and be it further

RESOLVED: That the MSMS House of Delegates (acting as the corporate body of Michigan Medical Service) then elect twenty-one new physician-members to the Board of Directors who will, after due consideration, fill the remaining vacancies (fourteen) on the board, which authority is provided them by Article II, Section 3 of the Michigan Medical Service Bylaws.

● RESOLUTION 89

30 years In, Out with $500 per Month
R. M. Stow, MD, Ingham County

HOUSE ACTION: Disapproved

Whereas, thirty years of service with corporations is now being negotiated as an acceptable duration of work before voluntary retirement with a guaranteed life income, and

Whereas, one of the real deterrents to retirement of older physicians is the lack of steady income, and

Whereas, if not now, soon physicians in general and probably the MSMS in particular, will be negotiating contracts with governmental agencies or private corporations for compensation for the services of physicians, therefore, be it

RESOLVED: That The Council be directed through a suitable committee to investigate various programs which could enable physicians to retire after 30 years of practice, and be it further

RESOLVED: That any future negotiations for doctors by the MSMS include this concept as a fringe benefit.

● RESOLUTION 90

Establishment of Negotiating Agents
David Kahn, MD, Ingham County

HOUSE ACTION: Substitute Resolution Adopted for Resolutions 10, 46, 47, 70, and 90—See Resolution 10

● RESOLUTION 91

Increased Allocations for Medical Schools
D. Bonta Hiscoe, MD, Ingham County

HOUSE ACTION: Approved

Whereas, there is an estimated shortage of 52,000 physicians in the nation, according to the United States Department of Health, Education, and Welfare, and

Whereas, there is an estimated shortage of more than 2,000 physicians in Michigan, according to requests for physicians on file with the Michigan Health Council Doctor Placement Service, and

Whereas, there are now 103 medical schools with others scheduled to open in the next several years — showing a sharp increase over the 72 schools at the end of World War II, and

Whereas, the Michigan Legislature has been allocating increasing amounts for the three medical schools in Michigan, and

Whereas, the Michigan Legislature passed into law Senate Bill No. 1179 which provides $195,000 additional for medical schools to permit them to receive $13,000 per full time equated registered freshman medical student in excess of their already-projected growths this fall; therefore be it

RESOLVED: That the MSMS voice its sincere appreciation to the Michigan legislature for the larger allocations to the three medical schools and for the current $195,000 special incentive grant; and be it further

RESOLVED: That MSMS respectfully encourage and assist the three medical schools in their plans to further expand their classes; and be it further

RESOLVED: That MSMS respectfully request the State Legislature to further increase allocations to the three schools so they can further increase their classes of freshmen medical students and thus graduate larger and larger classes, because there certainly is a need for more doctors in Michigan and the nation.

● RESOLUTION 92

Opposition to Contingency Fee System in Malpractice Cases
Daniel J. Wilhelm, MD, St. Clair

HOUSE ACTION: Referred to The Council for study

Whereas, the cost of physicians' malpractice insurance has risen exhorbitantly in the past few years, due to excessive awards in malpractice cases, and

Whereas, the patient, who may rightly deserve this award, often receives less than half because of excessive legal costs based on the contingency fee system, and

Whereas, the contingency fee system contributes to the awarding of excessive judgments; therefore be it

RESOLVED: That the MSMS feel the contingency fee system is unfair to the patient, the insurance carriers, and the medical profession; and be it further

RESOLVED: That MSMS again urge a continuing study of this problem by MSMS and the AMA, ultimately hoping to substitute a fee for service method of payment for legal services in place of the contingency fee system; and be it further

RESOLVED: That the Michigan Delegation to the AMA House of Delegates be instructed to introduce said resolutions at the next session of the AMA House of Delegates.

● RESOLUTION 93

Opposition to Anti-Substitution Repeal
Daniel J. Wilhelm, MD, St. Clair

HOUSE ACTION: Adopted As Amended

Whereas, the American Pharmaceutical Association has voted to launch state-level campaigns to repeal statutes banning brand substitutions by pharmacists, and

Whereas, Michigan appears likely to be an early target in this effort, and

Whereas, lack of specific information concerning the relative merits of so-called equivalent drug products makes it difficult, if not impossible, for pharmacists to intelligently substitute or use other brands on a reasonable or rational basis, and

Whereas, it is essential that the physician know what brand of drug product his patient is using for assurance that the same degree of absorption, blood level, duration of action, etc., will continue throughout the course of treatment, and

Whereas, legalized brand-switching, without the physician's knowledge or consent, could be hazardous to the patient and disruptive of the physician's treatment plan; therefore be it

RESOLVED: That this House of Delegates opposes and will resist all attempts to repeal the anti-substitution legislation, and be it further

RESOLVED: That a copy of this Resolution be transmitted to the AMA, the Michigan Board of Pharmacy, the Michigan State Pharmaceutical Association, the State Executive Office, the State Legislature and all nationally recognized pharmaceutical associations.

● RESOLUTION 94

Drug Abuse & Minors Consent
Daniel J. Wilhelm, MD, St. Clair

HOUSE ACTION: No Action

Whereas, the drug abuse problem is a critical social problem, and

Whereas, many young people trapped by this problem want help, but do not seek help because of fear of prosecution, identification and parental castigation, and

Whereas, the Michigan House of Representatives has acted favorably and passed House Bill 4794 which would allow physicians to treat minors with drug problems on the consent of the minor alone; therefore be it

RESOLVED: That we urge the Senate to act favorably and quickly and pass this needed legislation into state law, thus allowing physicians to be able to treat minors with drug abuse problems on the consent of the minor alone.

● RESOLUTION 95

Voluntary Elective Sterilization
Jack M. Stack, MD, Gratiot-Isabella-Clare County

HOUSE ACTION: Adopted As Amended

Whereas, every couple, in consultation with the physician of their choice, should be free to choose their own method of family limitation, and

Whereas, surgical sterilization is becoming a more prevalent choice of method for family limitation, and

Whereas, presently Blue Shield, governmental and other private insurance plans have restrictive policies regarding payment for surgical sterilization allowing payment only if the operation is done on a hospital bet patient for "medical indications", and

Whereas, many couples are denied the option of surgical sterilization for family limitation because of limited financial resources, and

Whereas, many hospital sterilization committees impose artificial restrictions such as age, parity and "medical indications" upon patients requesting sterilization; therefore be it

RESOLVED: That MSMS advise that hospitals discontinue using the sterilization committee procedure; and be it further

RESOLVED: That MSMS request Blue Shield, Medicaid and all other insurance and government medical plans to remove restrictions on payment for surgical sterilization on an in-patient or out-patient basis; and be it further

RESOLVED: That MSMS inform the Health Committees of the legislature and congress of this position and request that they use their influence to encourage insurance companies, government plans, etc., to provide payment for elective voluntary surgical sterilization.

● RESOLUTION 96

Encouragement of Family and Rural Practice
E. S. Woodworth, MD, Livingston County

HOUSE ACTION: Substitute Resolution Adopted for Resolutions 7, 13, 29, 50, 85 and 96—See Resolution 7

● RESOLUTION 97

The Multiplicity of Hospital Inspections
E. S. Woodworth, MD, Livingston County

HOUSE ACTION: Adopted As Amended

Whereas, there is a growing concern among both the public at large and the medical profession over the rapidly rising costs of hospital basic care, and

Whereas, general hospitals in Michigan today are besieged with a multiplicity of time-consuming, and therefore economically costly, inspections carried out by a variety of governmental agencies and professional organizations, and

Whereas, these various inspections are usually carried out completely separately in spite of frequently overlapping fields and a common parent organization, and

Whereas, there is a trend currently to increase both the number and frequency of such inspections; therefore be it

RESOLVED: That the Hospital Relations Committee be requested to study this problem and make recommendations for elimination of unnecessary inspections; and be it further

RESOLVED: That this committee report back to The Council as soon as possible or at the latest to the 1971 session of the House of Delegates.

● RESOLUTION 98

AMA Delegates to be Ex-Officio Members of The Council
E. S. Woodworth, MD, Livingston County

HOUSE ACTION: Adopted As Amended and Laid Over to 1971 Session

Whereas, the increasing complexity of the politics of medicine make it imperative to have the most efficient organizational structure possible to secure the cogent propagation of organized medicine's objectives, and

Whereas, The Council of the MSMS is the executive and directing body of the Society whenever the House is not in session, and

Whereas, the delegates of the AMA with their alternates are the only official and responsible representatives of MSMS at the national level, therefore be it

RESOLVED: That the MSMS Constitution and Bylaws be amended to make the Chairman of the AMA delegates, or his designated alternate, an ex-officio member of The Council of MSMS.

(Passage would require the following language changes in Article X, Section 1. (Added to the next to the last sentence). "The Chairman of the delegates to the AMA, or his designated alternate, shall serve on The Council as an ex-officio member.")

● RESOLUTION 99

Support of Michigan Medical Service Plan
James Fryfogle, MD, Wayne County

HOUSE ACTION: Disapproved

Whereas, Michigan Medical Service has been initiated, developed, maintained, and subsidized by the medical profession for thirty-one years as a community service, and

Whereas, under this sponsorship Michigan Medical Service has grown in size and scope until it is now a multi-million dollar corporation with benefits essential to the Michigan community, and

Whereas, five million subscribers rely on Michigan Medical Service for health insurance protection and are dependent on its continuation, and

Whereas, the responsibility for the direction of Michigan Medical Service must now be shared with government, consumers, and industry and their varied expertise be available through the Board of Directors of Michigan Medical Service, and

Whereas, it is essential to Michigan Medical Service, the medical profession, and the subscribers that physicians continue the direction of medical policy, and

Whereas, the Board of Directors of Michigan Medical Service has formulated and submitted to its corporate body a plan which will give physicians strong representation while at the same time grant representation to other health providers and consumers; therefore be it

RESOLVED: That this House of Delegates approve the plan for the restructuring of Michigan Medical Service as submitted by its Board of Directors; and be it further

RESOLVED: That the Delegates, as members of the corporate body of Michigan Medical Service, be advised to vote for the approval of this plan at the 1970 Annual Meeting of the corporate body of Michigan Medical Service.

● RESOLUTION 100

Medical Foundations
Ralph Cooper, MD, Wayne County

HOUSE ACTION: Adopted As Amended

Whereas, third party organizations are taking greater part in medical care, and

Whereas, Comprehensive Health Planning Council agencies are taking over all health planning in the State, and

Whereas, these agencies have already shown disregard for the expressed opinions of organized medicine, and

Whereas, numerous medical societies, including many in California, have established and successfully operated Medical Foundations to promote the distribution of medical services to the people of a given geographic area at reasonable costs, to preserve the freedom of choice of physician, to guard the patient-physician relationship and to work with prepaid medical plans which provide for freedom of selection of physician; therefore be it

RESOLVED: That the MSMS Council investigate the desirability of forming a Medical Foundation in Michigan and, if found desirable, take the necessary steps for forming such a Foundation.

● RESOLUTION 101

Medicare Home Health Services
H. M. Smathers, MD, Wayne County

HOUSE ACTION: Approved

Whereas, the original Medicare and Medicaid legislation included the provision of home health care services, and

Whereas, the agencies responsible for these services, whether a Visiting Nurse Association, health department, hospital or other qualified agency, understood that these services would be delivered in the traditional manner established in this country in 1786, and continued most successfully since, and

Whereas, all studies have shown that home health care is most economical, and when utilized properly can save the payee, the patient and the community vast sums of money, and

Whereas, in the past six months the Congress of the United States and the Department of Health, Education and Welfare have instructed Blue Cross, and other intermediaries to curtail home health services except under certain stipulated conditions, which have been found to be impractical, contrary to VNA tradition, and depriving a large segment of chronically-ill senior citizens of this vital and economical service, and

Whereas, this policy adopted by the Federal Government, without prior warning, has resulted in a denial of service to worthy patients and caused a serious cutback in recent VNA expansion, and

Whereas, retroactive denial of payment for services previously rendered has created a monumental financial hardship to the agencies and therefore the community will need to assume these services; therefore be it

RESOLVED: That the MSMS initiate action and urge its component county societies, every practicing physician in Michigan, and patients and their families immediately to contact members of Congress, the Department of Health, Education and Welfare as well as its intermediaries in protesting this unrealistic interpretation of Home Health Care and immediately return to traditional VNA service, and be it further

RESOLVED: That all concerned be urged to expand home health services because of its proven ability to cut the total cost of medical care more substantially than any other modality now being used.

● RESOLUTION 102

Change of MMS Service Policy to Indemnity Policy
D. B. Heilbronn, MD, Saginaw County

HOUSE ACTION: Referred to Legal Affairs Committee

Whereas, there has been an increasing chagrin on the part of participating physicians to continue the present Michigan Medical Service policy, and

Whereas, a greater number of participating physicians are questioning their ability to continue participating in a service policy, and

Whereas, the continued association with Michigan Medical Service demands cooperation of the carrier and vendors, therefore be it

RESOLVED: That the MSMS requests that the Legislature change the enabling act of Michigan Medical Service to allow an indemnity policy rather than the present service policy.

● RESOLUTION 103

Greater Cooperation with Michigan Hospital Association

R. Toteff, MD, Saginaw County

HOUSE ACTION: Adopted

Whereas, there is continuing discussion with prognostications that the hospital may be the center of all facets of community health care, and

Whereas, the physician is involved directly and indirectly in all the aspects of medical care, whether it be preventive, acute or chronic, rehabilitation, social, or environmental; therefore be it

RESOLVED: That The Council of MSMS exert greater efforts in joint development and planning with Michigan Hospital Association.

● RESOLUTION 104

Hospital Committee on Efficiency

R. Toteff, MD, Saginaw County

HOUSE ACTION: Adopted

Whereas, there is continuing discussion on ways and means of decreasing hospital costs, and

Whereas, responsibility for these costs is usually and frequently attributed to the physician, and

Whereas, there is increasing evidence that certain forces are predicting, and working toward the concept of medical care ultimately being based in or about community or regional hospitals, and

Whereas, the action of the Joint Committee on Accreditation of Hospitals modified and compromised the request for physicians on hospital boards, a policy approved by both MSMS and AMA houses of delegates, and

Whereas, the hospital relations committee of The Council at a Joint meeting with a liaison committee of the Michigan Hospital Association, approved the concept; therefore be it

RESOLVED: That the MSMS House of Delegates request that hospitals consider the formation of a committee of at least six members equally representing the executive committee of the hospital medical staff, the hospital administrative staff, and the hospital governing board; to act as a coordinating advisory committee reporting to the hospital board, and charged with the function of initiating or stimulating meaningful projects and activities to achieve increased effectiveness and economy, efficiency and quality medical care in the hospital; and be it further

RESOLVED: That a copy of this resolution be sent to the Joint Committee on Accreditation of Hospitals.

● RESOLUTION 105

Educational Program on Crime and Delinquency

Ralph Pino, MD, Wayne County

HOUSE ACTION: Adopted As Amended

Whereas, progress has advanced during the past years on the development at national levels of programs we have originated that relate to education of the public of the medical aspects of crime and delinquency, and

Whereas, the effects of drugs and chemicals on the bodies and minds of millions of Americans have led to many diseases and disabilities, and

Whereas, government and educational institutions are in need of testimony from the medical standpoint; therefore be it

RESOLVED: That the MSMS House of Delegates reaffirm its endorsement of the need for an educational program in support of the AMA in its continuing efforts to establish such an educational program to help combat crime and drug abuse as contributing factors to overall morbidity.

● RESOLUTION 106

Professional Liability Legislation

L. R. Zako, MD, Wayne County

HOUSE ACTION: Adopted As Amended

Whereas, many high risk physicians in the states of New Mexico and Hawaii have received notices that their professional liability insurance will not be renewed, and

Whereas, the practice of medicine without professional liability coverage is for all practical purposes impossible, and

Whereas, the State of Michigan would in all probability experience an exodus of physicians unable to obtain adequate professional liability coverage should this occur here; therefore be it

RESOLVED: That the MSMS propose appropriate legislation to require insurance companies doing business in the state to provide liability coverage for all duly licensed physicians and to prohibit any insurance carrier who stops providing professional liability insurance in the State of Michigan from underwriting any other form of insurance in the State; and be it further

RESOLVED: That the Society make every reasonable effort to obtain the cooperation of the Insurance Commissioner in support of such legislation and develop a public relations campaign to inform the public of the seriousness of the inability of some physicians to obtain professional liability insurance in order to gain public support for such legislation; and be it further

RESOLVED: That MSMS continue exploring the possibility of providing group coverage for the members of the Society, and be it further

RESOLVED: That immediate and continuing investigation be instituted by an appropriate committee of MSMS toward the solving of this problem and to bring this problem to the public's attention.

● RESOLUTION 107

Michigan State Medical Society Opposition to Bennett Amendment

Donato F. Sarapo, MD, Lenawee County

HOUSE ACTION: Approved

Whereas, the Bennett Amendment 851, Social Security Amendments, HR 17550, calls for the formation of "review teams" that would be created throughout the country for the purpose of evaluating the cost, quality, quantiy, and necessiy for services provided for Medicare-Medicaid patient, and

Whereas, the need for firm controls of utilization of medical care by a peer review is best performed by a medical audit and utilization review process by the medical staff in each hospital, or local medical society peer review mechanisms, and

Whereas, the government control over these matters would complicate things and would definitely increase the cost of rendering medical care; therefore be it

RESOLVED: That MSMS go on record as being opposed to The Bennett Amendment 851, Social Security Amendments of 1970, HR 17550.

● RESOLUTION 108

New Pictures for MSMS House of Delegate Leaders
V. A. Marks, MD, Midland County

HOUSE ACTION: Approved

Whereas, we have such handsome state leaders; therefore be it

RESOLVED: That they have new pictures taken to bring their place of dignity up to date in our handbooks.

● RESOLUTION 109

SAMA Representation in the House of Delegates
Harold F. Falls, MD, Washtenaw County

HOUSE ACTION: Adopted

Whereas, the SAMA is a recognized and established organization active at each of the three state medical schools, and

Whereas, this organization represents a sizable number of future physicians, and

Whereas, the future medical environment will largely be affected by decisions of this House, and

Whereas, the medical student segment of the medical profession represents an heretofore untapped reservoir of ideas, and

Whereas, this House has benefited from the limited participation of students in the past; therefore be it

RESOLVED: That this House of Delegates expand the current participation of students by approving the seating, with full privileges in the House of Delegates of a student from each established medical school, who is a member of the SAMA.

By a two-thirds vote, the rules were suspended, and the following Bylaw changes were adopted and given immediate effect:

Chapter 9—HOUSE OF DELEGATES—Sec. 1. COMPOSITION—The first sentence to be changed to read: "The House of Delegates shall be composed of members elected by the component county societies and each recognized specialty section, AND A DELEGATE FROM EACH STUDENT AMERICAN MEDICAL ASSOCIATION CHAPTER OF EACH ESTABLISHED MEDICAL SCHOOL IN THE STATE OF MICHIGAN."

Chapter 9—HOUSE OF DELEGATES—Sec. 3. ELECTION—CERTIFICATION—The last sentence to be changed to read: "Promptly after election the Secretary of the component county society or recognized specialty section OR OF THE DESIGNATED STUDENT AMERICAN MEDICAL ASSOCIATION CHAPTER shall certify the names of its delegates and alternate delegates to the Secretary of this Society."

SPECIAL MEMBERSHIPS

THE REFERENCE COMMITTEE on Special Memberships, Donald D. Finlayson, MD, Chairman, recommended approval of the following special memberships as recommended by the component medical societies and certified by the Secretary of MSMS in accordance with the Bylaws:

Retired Memberships

Berrien — Harold D. Huff, MD.
Calhoun — Kenneth H. Lowe, MD; Duard L. Finch, MD; Clarke W. Royer, MD.
Ingham — Lawrence A. Drolett, MD.
Jackson — Loyd L. Olsen, MD.
Kalamazoo — Robert J. Armstrong, MD; Peter Paul Brue, MD; E. Gifford Upjohn, MD.
Kent — Morris Wilderom, MD.
Lenawee — P. Linford Miller, MD.
Midland — William A. Maynard, MD; Wilbur Towsley, MD.
Oakland — William S. Hathaway, MD.
Ottawa — Edwin E. Vanderberg, MD.
Saginaw — Homer G. Slade, MD; William P. Martzowka, MD.
St. Clair — Edwin H. Fenton, MD.
Tuscola — Robert R. Howlett, MD.
Van Buren — Frederick M. Boothby, MD; Edwin H. Terwilliger, MD.
Washtenaw — Cameron Haight, MD.
Wayne — Morris S. Brent, MD; Marion W. Jocz, MD; Bernard L. Lieberman, MD; Edward I. Mintz, MD; John B. Sarracino, MD.

Life Memberships

Allegan — Elwin B. Johnson, MD; James E. Mahan, MD.
Branch — James A. Thomas, MD.
Chippewa-Mackinac — Lyman M. McBryde, MD.
Ionia-Montcalm — Loyd S. Dunkin, MD.
Kent — William R. Torgerson, MD; Robert G. Laird, MD; Abraham L. Pott, MD.
Menominee — L. Grant Glickman, MD.
Muskegon — Shattuck W. Hartwell, MD.
Oakland — Chauncy G. Burke, MD; James P. McConkie, MD.
Sanilac — S. Martin Tweedie, MD; M. Cole Seager, MD.
Tuscola — Ewald C. Swanson, MD.
Washtenaw — Edgar A. Kahn, MD; Albert C. Kerlikowske, MD; James N. P. Struthers, MD.
Wayne — Morris E. Bauchman, MD; Abraham M. Booklien, MD; Gordon T. Brown, MD; Perry P. Burnstine, MD; Lawrence H. Butler, MD; Harold W. Carlson, MD; George M. Childs, MD; John M. Dorsey, MD; Earl H. Engel, MD; Joseph W. Eschbach, MD; Martin S. Feldstein, MD; Elisha S. Gurdjian, MD; Orville J. Hastings, MD; Philip J. Howard, MD; Irving S. Katzman, MD; Ross M. Knox, MD; Robert C. Leacock, MD; Samuel J. Levin, MD; Harold C. Mack, MD; Don W. McLean, MD; Mark R. McQuiggan, MD; Earl G. Merritt, MD; Thomas H. Miller, MD; Scipio G. Murphy, MD; Randall M. O'Rourke, MD; Alvin E. Price, MD; Lambert P. Rahm, MD; Nathan H. Schlafer, MD; Israel Z. Silvarman, MD; Chester E. Stellhorn, MD; Samson S. Wittenberg, MD; Sidney L. Berman, MD; J. Lewis Dill, MD; Charles H. Ewing, MD; Barney B. Israel, MD; Francis S. Porretta, MD; Saul Rosenzweig, MD; William L. Schields, MD.

Honorary Membership

Delta-Schoolcraft — H. J. Parkhurst, MD.

THE HOUSE adopted the report of the Reference Committee.

PRESENTATIONS AND AWARDS

FIFTY YEAR AWARDS

President Robert J. Mason, MD, presented the Fifty Year Awards to:

Paul S. Barker, MD, *Washtenaw County*
Otto O. Beck, MD, *Oakland County*
Bernard Bernbaum, MD, *Wayne County*
William Boles, MD, *Genesee County*
Elmer Carroll, MD, *Wayne County*
John H. Cobane, MD, *Wayne County*
Frank E. Curtis, MD, *Wayne County*
Robert J. Elvidge, MD, *Wayne County*
A. S. Guimaraes, MD, *Wayne County*
Fred Hodges, MD, *Washtenaw County*
William A. Hudson, MD, *Wayne County*
William E. Johnston, MD, *Wayne County*
Roy C. Kingswood, MD, *Wayne County*

Shmarya Kleinman, MD, *Wayne County*
Raymond H. Koebel, MD, *Wayne County*
Charles B. Lakoff, MD, *Wayne County*
Earle D. MacKenzie, MD, *Wayne County*
Kenneth C. MacPherson, MD, *Wayne County*
John A. Maloney, MD, *Wayne County*
Norman Miller, MD, *Washtenaw County*
Myron H. Miller, MD, *Wayne County*
Arthur H. Mollmann, MD, *Kent County*
George Moore, MD, *Macomb County*
Harry M. Nelson, MD, *Wayne County*
Constantine Oden, MD, *Muskegon County*
Clarence I. Owen, MD, *Wayne County*
A. Hazen Price, MD, *Wayne County*
Frank H. Purcell, MD, *Wayne County*
Rudolph W. Streat, MD, *Genesee County*
William S. Williams, MD, *Genesee County*
Emery D. Winfield, MD, *Kent County*
Cyril Youngs, MD, *Kalamazoo County*

NATIONAL PRESIDENTS AWARDS

Awards were presented to the following for their service as presidents of national medical organizations:

George Aitken, MD, Grand Rapids, President, American Academy of Orthopaedic Surgeons

Meyer O. Cantor, MD, Detroit, President, American Society of Abdominal Surgeons

Marvin H. Pollard, MD, Ann Arbor, President, World Organization of Gastroenterology

Myron E. Wegman, MD, Ann Arbor, President, The Federation of Associations of Schools of the Health Professions

Robert J. Willson, MD, Ann Arbor, President, American College of Obstetrics and Gynecology

James C. Cook, MD, Detroit, President, American Roentgen Ray Society

MSMS SPECIAL AWARDS

Awards were presented to the following "friends of medicine" for their service as presidents of national organizations:

Jean Pearson, Detroit, President, National Association of Science Writers

Helen J. Claytor, Grand Rapids, President, Young Womens Christian Association of the USA

Warren F. Tryloff, East Lansing, President, Professional Convention Management Association

MSMS FLAG AWARDS

Awards were presented to the following doctors who have served as presidents of state-wide non-medical organizations:

Edward W. Green, MD, Detroit, President, Michigan Heart Association

John Kitchel, MD, Grand Haven, President, Michigan United Conservation Clubs

Marjorie P. Meyers, MD, Detroit, President, Michigan Diabetes Association

Archie Narotzky, MD, Ishpeming, President, Michigan Epilepsy Center and Association

MSMS AWARDS TO PHYSICIAN OF THE WEEK

Awards were presented to the following MSMS members who served for one week during 1970 as volunteer "Physician of the Week" in Lansing:

Robert Huebner, MD, Hastings
Louis R. Zako, MD, Allen Park
Charles L. Oppy, MD, Roscommon
Raymond L. Hockstad, MD, Escanaba
F. P. Rhoades, MD, Detroit
Jack M. Stack, MD, Alma
James D. Fryfogle, MD, Southfield
Perry W. Greene, Jr., MD, Grand Rapids
Oscar D. Stryker, MD, Mount Clemens
Brooker L. Masters, MD, Fremont
William A. DeYoung, MD, Saginaw
Frederick S. Gillett, MD, Grand Rapids
Roger F. McNeill, MD, Grosse Pte. Farms
Thomas C. Payne, MD, Lansing
Frederick W. Bryant, MD, Birmingham
Mahlon S. Sharp, MD, Lansing
Keith M. Holmes, MD, Pontiac
Edwin M. Knights, Jr., MD, Southfield
John W. Grigg, MD, Bay City

ELECTIONS

The House of Delegates elected the following MSMS Officers, Councilors, and American Medical Association Delegates and Alternate Delegates:

President-Elect — Sidney Adler, MD, Detroit
Speaker of the House — Vernon V. Bass, MD, Saginaw
Vice Speaker of the House — James D. Fryfogle, MD, Southfield

Councilors

1st District: Ralph R. Cooper, MD, Detroit
1st District: Edward J. Tallant, MD, Detroit
1st District: Frank B. Bicknell, MD, Detroit
1st District: Brock E. Brush, MD, (to fill unexpired term to 1972)
4th District: W. Kaye Locklin, MD, Kalamazoo
5th District: Noyes L. Avery, Jr., MD, Grand Rapids
6th District: Ernest P. Griffin, Jr., MD, Flint
13th District: Donald T. Anderson, MD, Kingsford (to fill unexpired term to 1972)
14th District: Donato F. Sarapo, MD, Adrian

Delegates to the American Medical Association

(January 1, 1971 to December 31, 1972)
John J. Coury, MD, Port Huron
George W. Slagle, MD, Battle Creek
Donald N. Sweeny, MD, Detroit
James A. Witter, MD, Rochester

Alternate Delegates to the American Medical Association

(January 1, 1971 to December 31, 1972)
(in order of seniority)
James C. Danforth, Jr., MD, Detroit
Marjorie Peebles Meyers, MD, Detroit
Robert C. Prophater, MD, Bay City
Vernon V. Bass, MD, Saginaw

REFERENCE COMMITTEES

CONSTITUTION & BYLAWS

David J. Millard, MD, Van Buren, *Chairman*
Lawrence G. Bateman, MD, Genesee
Stuart M. Gould, Jr., MD, Washtenaw
George T. Kelleher, MD, Calhoun
Frederick H. Lindenfeld, MD, Berrien
John H. Rick, MD, Branch

Councilor Advisors:

John J. Coury, MD, Port Huron
Harold F. Falls, MD, Ann Arbor

CREDENTIALS & TELLERS

Bruce D. Bauer, MD, Oakland, *Chairman*
John W. MacKenzie, Jr., MD, Genesee
Arthur Z. Ostrowski, MD, Wayne
Earl A. Rinkenberger, MD, Macomb
Neal A. Vanselow, MD, Washtenaw

HEALTH INSURANCE & MEDICAL SERVICES

Raymond J. Barrett, MD, Wayne, *Chairman*
Frederick S. Gillett, MD, Kent
Jack Hoogerhyde, MD, Kent
F. Alan Kennedy, MD, Berrien
Richard J. McMurray, MD, Genesee
Frederick C. O'Dell, Jr., MD, Alpena-Alcona-Presque Isle
Robert E. Rice, MD, Ionia-Montcalm
Robert J. Toteff, MD, Saginaw
Joseph A. Witter, MD, Wayne

Councilor Advisors:

Sidney Adler, MD, Detroit
Ernest P. Griffin, Jr., MD, Flint
Don W. McLean, MD, Detroit

MISCELLANEOUS BUSINESS

Arnold L. Brown, MD, Oakland, *Chairman*
Charles L. Conaway, MD, Lapeer
Ili J. Igna, MD, Wayne
David Kahn, MD, Ingham
F. Patrick McQuillan, MD, Jackson
Charles L. Oppy, MD, North Central

Councilor Advisors:

William A. LeMire, MD, Escanaba
John R. Pedden, MD, Grand Rapids
A. Carl Stander, MD, Saginaw

PUBLIC & PROFESSIONAL RELATIONS

James D. Fryfogle, MD, Wayne, *Chairman*
Fred E. Caumartin, MD, Wayne
Harold A. Furlong, MD, Oakland
Paul G. Goodreau, MD, Houghton-Baraga-Keweenaw
Duane E. Heilbronn, MD, Saginaw
D. Bonta Hiscoe, MD, Ingham
Henry A. Scovill, MD, Washtenaw
Eber B. Sherman, MD, Eaton
Edward J. Tallant, MD, Wayne
Edwin S. Woodworth, MD, Livingston

Councilor Advisors:

Don Marshall, MD, Kalamazoo
Adam C. McClay, MD, Traverse City
Robert C. Prophater, MD, Bay City

REPORTS OF COUNCIL & OFFICERS

Edward E. Elder, Jr., MD, Oakland, *Chairman*
Frank B. Bicknell, MD, Wayne
James I. Clark, MD, Allegan
Herbert W. Harris, MD, Ingham
Keate T. McGunegle, MD, Sanilac
Charles W. Oakes, Jr., MD, Huron
Daniel J. Wilhelm, MD, St. Clair

Councilor Advisors:

Ross V. Taylor, MD, Jackson
Ralph R. Cooper, MD, Detroit

RESOLUTIONS

Robert M. Stow, MD, Ingham, *Chairman*
Clifford W. Colwell, MD, Genesee
Charles E. Darling, MD, Wayne
Robert J. Fisher, MD, Washtenaw
Richard R. Galpin, MD, Oakland
V. A. Marks, MD, Midland
Donato F. Sarapo, MD, Lenawee
Homer M. Smathers, MD, Wayne

Councilor Advisors:

J. Robert Franck, Jr., MD, Wakefield
Brooker L. Masters, MD, Fremont
Milton R. Weed, MD, Grosse Pointe Park

RULES & ORDER OF BUSINESS

Frank B. Walker, II, MD, Wayne, *Chairman*
Robert H. Evans, MD, St. Joseph
W. Kaye Locklin, MD, Kalamazoo
Lewis E. Simoni, MD, Genesee
H. Clay Tellman, MD, Muskegon
William J. Yott, MD, Wayne

SPECIAL MEMBERSHIPS

Donald D. Finlayson, MD, Chippewa-Mackinaw, *Chairman*
Robert Huebner, MD, Barry
Frank H. Power, MD, Grand Traverse-Leelanau-Benzie
Kornelius Van Goor, MD, Kent

STATE & FEDERAL LEGISLATION

Noyes L. Avery, Jr., MD, Kent, *Chairman*
Richard J. Bower, MD, Kalamazoo
Benjamin Jeffries, MD, Wayne
Paul T. Lahti, MD, Oakland
John H. McLaughlin, MD, Oakland
William Rottschaefer, MD, Ottawa
Louis R. Zako, MD, Wayne

Councilor Advisors:

Robert M. Leitch, MD, Union City
James J. Lightbody, MD, Detroit
Sydney Scher, MD, Mount Clemens

WAYS & MEANS

John W. Moses, MD, Wayne, *Chairman*
Richard C. Deming, MD, Jackson
Arthur F. Dundon, MD, Grand Traverse-Leelanau-Benzie
A. John Neerker, MD, Kalamazoo
Herbert L. Nigg, MD, Tuscola

Councilor Advisors:

Kenneth H. Johnson, MD, Lansing
Robert K. Whiteley, MD, Detroit
John R. Ylvisaker, MD, Pontiac

PARLIAMENTARIAN

A. Stewart Kerr, Detroit

RECORD OF ATTENDANCE

1970 MSMS House of Delegates

OFFICERS

	Meetings					
	1st	2nd	3rd	4th	5th	6th
Speaker:						
James B. Blodgett, MD	X	X	X	X	X	X
Vice Speaker:						
Vernon V. Bass, MD	X	X	X	X	X	X
Immediate Past President:						
James J. Lightbody, MD	X	X	X	—		X
Secretary:						
Kenneth H. Johnson, MD	X	X	X	X	X	X

DELEGATES

	Meetings					
	1st	2nd	3rd	4th	5th	6th
ALLEGAN						
James I. Clark, MD	X	X	X	X	X	X
ALPENA-ALCONA-PRESQUE ISLE						
Frederick C. O'Dell, Jr., MD	X	X	X	X	X	X
BARRY						
Robert J. Huebner, MD	X	X	X	X	X	X
BAY-ARENAC-IOSCO						
John T. Geneczko, MD	X	X	X	—	X	—
Paul W. Rowe, MD	X	—	X	X	X	—
BERRIEN						
F. Alan Kennedy, MD	X	X	X	X	X	X
Frederick H. Lindenfeld, MD	X	X	X	X	—	—
BRANCH						
John J. Rick, MD	X	X	X	X	X	X
CALHOUN						
George T. Kelleher, MD	X	X	X	X	X	X
Russel C. Rowan, MD	X	X	X	X	X	X
CASS						
Lowell D. Smith, MD	X	X	X	X	X	—
CHIPPEWA-MACKINAC						
Donald D. Finlayson, MD	X	X	X	X	X	X
CLINTON						
James M. Grost, MD	X	X	X	X	X	X
DELTA-SCHOOLCRAFT						
Donald N. Fitch, MD	X	X	X	X	X	X
DICKINSON-IRON						
Donald T. Anderson, MD	X	X	X	X	X	—
EATON						
Eber B. Sherman, MD	X	X	X	X	X	—
GENESEE						
Clifford W. Colwell, MD	X	X	X	X	X	X
Lewis E. Simoni, MD	X	—	X	X	X	X
Richard J. McMurray, MD	X	X	X	X	—	X
John W. MacKenzie, Jr., MD	—	X	X	X	X	X
Charles A. Thompson, MD	X	X	X	X	X	X
Lawrence G. Bateman, MD	X	X	X	X	X	X
John Quin, Jr., MD	X	X	X	X	X	X
GOGEBIC						
John R. Franck, Jr., MD	X	X	X	X	X	X
GRAND TRAVERSE-LEELANAU-BENZIE						
Frank H. Power, MD	X	X	X	X	—	—
Arthur F. Dundon, MD	X	X	X	X	—	—
GRATIOT-ISABELLA-CLARE						
John M. Wood, MD; and	X	—	X	X	X	X
Jack M. Stack, MD	—	X	—	—	—	—
HILLSDALE						
Clark B. Smith, MD	X	X	X	X	X	—
HOUGHTON-BARAGA-KEWEENAW						
Paul G. Goodreau, MD	—	X	—	X	X	X
HURON						
Charles W. Oakes, Jr., MD	X	X	X	X	X	X
INGHAM						
Charles O. Long, Jr., MD	X	X	—	X	X	X
Robert M. Stow, MD	X	X	X	X	X	X
D. Bonta Hiscoe, MD	X	X	X	X	X	—
David Kahn, MD	X	X	X	X	X	—
Herbert W. Harris, MD	X	X	X	X	X	X
David Siegel, MD	—	X	—	X	X	—
IONIA-MONTCALM						
Robert E. Rice, MD	X	—	X	X	X	—
JACKSON						
F. Patrick McQuillan, MD	X	X	X	X	X	X
Richard C. Deming, MD	X	X	X	X	X	X
KALAMAZOO						
W. Kaye Locklin, MD	X	X	X	X	X	X
A. John Neerken, MD	X	X	X	X	X	X
Thomas E. Andrews, MD		X	X	X	X	—
Richard J. Bower, MD	X	X	X	X	X	X
Roger A. Scholten, MD	X	X	X	X	X	X
KENT						
Harvey M. Andre, MD	X	X	X	X	X	X
Noyes L. Avery, MD	X	X	X	X	X	X
Fred C. Brace, MD	X	X	X	X	X	X
Frederick S. Gillett, MD; and	X	—	X	X	X	X
William E. Kincaid	—	X				
William Haeck, MD	X	X	X	X	X	X
Jack Hoogerhyde, MD	X	X	X	X	X	X
Jack G. Lukens, MD; and	X	X	X	X	X	—
Robert D. Burton, MD						X
Victor A. Notier, MD	X	X	X	X	X	X
Kornelius Van Goor, MD	X	X	X	X	X	X
LAPEER						
Charles E. Conaway, MD	X	X	X	X	X	—
LENAWEE						
Donato F. Sarapo, MD	X	X	X	X	X	X
LIVINGSTON						
Edwin S. Woodworth, MD	X	X	X	X	—	—
LUCE — Not Represented						
MACOMB						
Peter V. Kane, MD	X	X	X	X	X	X
Earl A. Rinkenberger, MD	-	-	X	X	X	X
Thomas J. Setter, MD	-	-	X	X	—	—
Gerald W. Morris, MD	X	X	X	X	—	--
MANISTEE — Not Represented						
MARQUETTE-ALGER						
George M. Wilson, Jr., MD	X	X	X	X	X	—
MASON						
William F. Sutter, MD	X	X	X	X	X	X
MECOSTA-OSCEOLA-LAKE						
James L. Tyson, MD	X	X	X	X	X	—
MENOMINEE						
William S. Jones, Jr., MD	X	X	X	X	X	X
MIDLAND						
V. A. Marks, MD; and	X	X	X	X	X	—
Charles A. Willison, MD					—	X
MONROE						
S. Newton Kelso, Jr., MD	X	X	X	X	—	—
MUSKEGON						
H. Clay Tellman, MD	X	X	X	X	X	—
Clarence A. Vandervelde, MD; and	X	X	X	X		—
Leland E. Holly, MD					X	X
Howard V. Sanden, MD	X	X	X	X	X	—
NEWAYGO						
Robert E. Paxton, MD	X	X	X	—	X	X

	Meetings					
	1st	2nd	3rd	4th	5th	6th
NORTH CENTRAL						
Charles L. Oppy, MD	X	X	X	X	X	X
NORTHERN MICHIGAN						
Jack R. Postle, MD	X	X	X	X	X	X
OAKLAND						
Paul T. Lahti, MD	X	X	X	X	X	X
Harold A. Furlong, MD	X	X	X	X	X	X
Richard R. Galpin, MD	X	X	X	X	X	X
Zachary F. Endress, MD	X	X	X	X	X	X
John H. McLaughlin, MD	X	X	X	X	X	
Shelby M. Baylis, MD			X	X	X	X
Worth W. Henderson, MD	X	X	X	X	X	X
Edward E. Elder, Jr., MD	X	X	X	X	X	X
Arnold L. Brown, MD	X	X	X	X	X	X
Bruce D. Bauer, MD; and	X	X		—	X	X
E. William Bauer, MD			X	X	—	—
James A. Read, MD	X	X	X	X	X	—
John B. Bryan, MD	X	X	X	X	X	X
Kenneth L. Urwiller, MD	X	X	X	X	X	X
Robert L. Tupper, MD	X	X	X	X	X	X
OCEANA						
John J. Vrbanac, MD	X	X	X	X	X	X
ONTONAGON — Not Represented						
OTTAWA						
William Rottschaefer, MD	X	X	X	X	X	—
Alvin Bonzelaar, MD	X	X	X	X	X	—
SAGINAW						
Roy J. Gerard, MD	X	X	X	X	X	X
Duane B. Heilbronn, MD	X	X	X	X	X	X
Robert J. Toteff, MD	X	—	X	X	X	X
Jack L. Barry, MD	X	X	X	X	X	X
ST. CLAIR						
Charles N. Hoyt, MD	X	X	X	X	X	—
Daniel J. Wilhelm, MD	X	X	X	X	X	X
ST. JOSEPH						
Robert H. Evans, MD	X	X	X	X	X	X
SANILAC						
Keate T. McGunegle, MD	X	X	X	X	X	X
SHIAWASSEE						
Henry T. Forsyth, MD	X	X	X	X	X	X
TUSCOLA						
Herbert L. Nigg, MD	X	X	—	X	—	—
VAN BUREN						
David J. Millard, MD	X	X	X	X	X	X
WASHTENAW						
Henry A. Scovill, MD	X	X	X	X	X	X
Stuart M. Gould, Jr., MD	X	X	X	X	X	X
John W. Henderson, MD; and	X	X	—	—	—	—
Lyle D. Elliott, MD	—	—	X	X	X	—
Beverly C. Payne, MD	X	X	X	X	X	X
Clarence E. Crook, MD	X	X	X	X	X	X
Harold F. Falls, MD	X	X	X	X	X	X
Harry A. Towsley, MD; and	X	X	X	X	X	—
Robert M. Oneal, MD	—	—	—	—	—	X
Neal A. Vanselow, MD	X	X	X	X	X	X
Howard R. Williams, MD	X	X	X	X	X	X
WAYNE						
Sidney Adler, MD	X	X	X	X	X	X
Robert D. Allaben, MD	X	X	X	X	X	X
Richard D. Anslow, MD	X		—	—	—	—
Raymond J. Barrett, MD	X	X	X	X	X	—
Frank B. Bicknell, MD	X	X	X	X	X	X
Alexander Blain, III, MD	X		—	—	X	X
Marshall J. Blondy, MD	X	X	X	X	X	—
Brock E. Brush, MD	X	X	X	X	X	X
Fred E. Caumartin, MD	X	X	X	X	X	X
Ned I. Chalat, MD	X		—	X	X	X
Paul J. Connolly, MD	X		X	X	X	X
Ralph R. Cooper, MD	X	X	X		X	X
James C. Danforth, MD	X	X	X	—	X	X
Charles E. Darling, MD	X	X	X		X	X
Henry M. Domzalski, MD	X	X	X	X	X	X
Paul R. Dumke, MD	X	X	X	X	X	
Thomas M. Flake, MD	X			X	X	X
C. Jackson France, MD	X	X	X	—	X	X
Eugene L. Freitas, MD	X	X	X	X	X	—
James D. Fryfogle, MD	X	X	X	X	X	
Robert H. Hamburg, MD	X	X	X	X	—	X
Louis F. Hayes, MD	X	X	X	X	X	—
Louis E. Heideman, MD	X		X	X	X	X
Homer A. Howes, MD	X	X	X	X	X	X
H. Ross Hume, MD	X	X		—	X	
Eli J. Igna, MD	X	X	X	X	X	X
Benjamin Jeffries, MD	X	X	X	X	X	X
James M. Kennary, MD	X	X	X	X	X	X
Kenneth L. Krabbenhoft, MD	X		X		—	X
Conrad R. Lam, MD	X	X		X	X	X
Richard L. Lamont, MD	X		X	X		X
Luther L. Leader, MD	X				X	—
Arthur B. Levant, MD	X	X	X	X	X	X
Gerald H. Mandell, MD	X	X	X	X	X	X
George Mogill, MD	X	X	X	X	X	X
John W. Moses, MD	X	X	X		—	X
John W. Moynihan, MD	X		—	—	—	—
Ralph H. Pino, MD	X	X	X	X	X	X
George F. Porretta, MD	X		X	X	X	X
Kenneth J. Ray, MD	X	X	X	—	X	X
Francis P. Rhoades, MD	X	X	X	X	X	—
Leon Rottenberg, MD	X	—	—	—	—	X
I. Walter Silver, MD	—	—	X	X	X	—
Homer M. Smathers, MD	X	X	X	X	X	X
Lee B. Stevenson, MD	X	X	X	X	X	X
Edward J. Tallant, MD	X	X	X	X	X	X
Arthur A. Ulmer, MD	X	X	X	—	—	X
Frank B. Walker, III, MD	X	X	X	X	X	X
Robert K. Whiteley, MD	X	X	X	X	X	X
Irwin A. Wilner, MD	X	X	X	—	X	X
Joseph A. Witter, MD	X	—	X	X	X	X
Joseph J. Woods, MD	—	—	X	X	—	X
William J. Yott, MD	X	X	X	X	X	X
Louis R. Zako, MD	X	X	X	—	X	X
Michael N. Zelenock, MD	X	—	X	X	X	X
WEXFORD-MISSAUKEE						
Dennis E. Van Alst, MD	X	X	X	X	X	X
SECTION DELEGATES						
ALLERGY AND APPLIED IMMUNOLOGY						
James A. McLean, MD	X	X	X	—	—	X
ANESTHESIOLOGY						
Bernard J. Sivak, MD	Credential, but no roll call ticket					
DERMATOLOGY						
Robert J. Schoenfeld, MD	—	—	X		—	—
GASTROENTEROLOGY — Not Represented						
GENERAL PRACTICE						
Douglas A. Haddock, Jr., MD	X	X	X	X	X	X
INTERNAL MEDICINE						
William B. McIntyre, MD	X	X	X	X	X	X
NEUROLOGY						
Mark C. Levine, MD	X	X	X	X	X	X
NEUROLOGICAL SURGERY						
H. Harvey Gass, MD			X	—		
OBSTETRICS-GYNECOLOGY						
Roger W. Postmus, MD	Credential, but no roll call ticket					
OCCUPATIONAL MEDICINE						
Benjamin B. Holder, MD	Credential, but no roll call ticket					
OPHTHALMOLOGY						
Fleming A. Barbour, MD	Credential, but no roll call ticket					
ORTHOPEDIC SURGERY						
John O. Goodsell, MD	Credential, but no roll call ticket					
OTOLARYNGOLOGY						
John W. Grigg, MD	X	X			—	—
PATHOLOGY						
Leo W. Walker, MD	X					—
PEDIATRICS						
Wilfred S. H. Nolting, MD	Credential, but no roll call ticket					
PHYSICAL MEDICINE						
Jack R. Grommons, MD	X	—	X	X	X	—
PLASTIC SURGERY						
Alexander P. Kelly, MD	X	X	X	X	X	—
PROCTOLOGY						
Donald J. Pearson, MD	X	X	X	X	X	—
PSYCHIATRY						
Stephen C. Mason, III, MD	X	X	X	X	X	—
PUBLIC HEALTH AND PREVENTIVE MEDICINE						
Winston B. Prothro, MD	X	X	X	X	X	X
RADIOLOGY						
Robert A. Songe, MD	X	X	X	X	X	—
SURGERY — Not Represented						
THORACIC SURGERY — Not Represented						
UROLOGY — Not Represented						
MEDICAL STUDENTS						
MICHIGAN STATE UNIVERSITY SCHOOL OF HUMAN MEDICINE						
Michael Shier	X	X	X	X	X	—
Paul Werner	X	X	X	X	X	X
Dave VanderWall	X	X	X	X	X	X
WAYNE STATE UNIVERSITY SCHOOL OF MEDICINE						
Marek Bozdech	X	X	X	X	X	—
David Hoekenga	X	—	—	—	—	—
UNIVERSITY OF MICHIGAN SCHOOL OF MEDICINE						
Jeffrey Callen	X	X	—	—	—	—
Steven Rodis	X	X	X	X	X	—

THE LIBRARY
UNIVERSITY OF CALIFORNIA
San Francisco Medical Center
THIS BOOK IS DUE ON THE LAST DATE STAMPED BELOW

7 DAY LOAN

7 DAY
DEC 28 1971

RETURNED
DEC 29 1971

7 DAY
MAY 27 1973

RETURNED
MAY 22 1973

7 DAY
NOV 9 1976

RETURNED
NOV 3 1976

7 DAY
MAR 28 1978

RETURNED
MAR 21 1978

7 DAY
MAY 23 1978

RETURNED
MAY 24 1978

25m-10,'67 (H5524s4) 4315

San Francisco
Medical Center
LIBRARY
UNIVERSITY OF CALIFORNIA

261224